

# CHIP Member Handbook

Aetna Better Health (Texas)



Tarrant/Bexar  
Service Areas —  
March 2012

To learn more, please call  
1-800-306-8612 (Tarrant) or  
1-800-248-7767 (Bexar)

[www.aetnamedicaid.com](http://www.aetnamedicaid.com)

Aetna Better Health  
covers members in the  
following counties:

Tarrant Service Area: Denton,  
Hood, Johnson, Parker, Tarrant  
and Wise Counties.

Bexar Service Area: Atascosa,  
Bandera, Bexar, Comal, Guadalupe,  
Kendall, Medina, and Wilson  
Counties.

 **CHIP** We've got your  
kids covered.

TX-12-01-38 (3/12)

 **Aetna**<sup>®</sup>  
Better Health

# Aetna Better Health CHIP/ CHIP Perinate Newborn / CHIP Perinate Member Handbook

To learn more, please call 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar)

[www.aetnamedicaid.com](http://www.aetnamedicaid.com)

Aetna Better Health covers Members in the following counties:

**Tarrant Service Area:** Tarrant, Denton, Hood, Johnson, Parker, and Wise Counties.

**Bexar Service Area:** Bandera, Bexar, Atascosa, Comal, Guadalupe, Kendall, Medina, and Wilson Counties.

Tarrant/Bexar Service Area – March 2012

TXC-11-05-03



## Important Numbers

Your/ Your Child's CHIP ID Number \_\_\_\_\_

Your/ Your Child's Primary Care Provider Name \_\_\_\_\_

Your/ Your Child's Primary Care Provider Address \_\_\_\_\_

Your/ Your Child's Primary Care Provider Phone \_\_\_\_\_

**In case of an emergency, call 911 or your local emergency hotline.**

**Visit the website:** [www.aetnamedicaid.com](http://www.aetnamedicaid.com)

**Call us:** **Aetna Better Health Member Services**

Toll-free:

**Tarrant Service Area: 1-800-245-5380**

**Bexar Service Area: 1-866-818-0959**

English/Spanish Interpreter Services available

Member Services Hours: Monday – Friday 8 a.m. – 5 p.m.

After Hours: Leave a message on the voice mail box

**Write us:**

**Aetna Better Health**

Attention: Aetna Better Health Member Services

PO Box 569150

Dallas, TX 75356-9150

**TTY:** For people that are deaf or hearing impaired, please call through the Relay of Texas TTY line at 1-800-735-2989 and ask them to call the Aetna Better Health Member Services Line.

### Important Phone Numbers

<b>CHIP/CHIP Perinate Newborn/CHIP Perinate</b>	
<b>Informed Health<sup>®</sup> Line (Health information from a registered nurse) 24 hours a days, 7 days a week</b>	<b>1-800-556-1555</b>
<b>CHIP Help Line</b>	<b>1-800-647-6558</b>
<b>CHIP/CHIP Perinate Newborn</b>	
<b>Block Vision Services</b>	<b>1-800-879-6901</b>
<b>Behavioral Health Services (includes mental health and substance abuse)* 24 hours a days, 7 days a week</b>	<b>1-800-245-5380 (Tarrant)</b> <b>1-866-818-0959 (Bexar)</b>
<b>CHIP Dental Managed Care Organizations</b>	
<b>Delta Dental Insurance Company</b>	<b>1-866-561-5891</b>
<b>DentaQuest</b>	<b>1-800-508-6775</b>
<b>MCNA Dental</b>	<b>1-800-494-6262</b>

\*For behavioral health care, call us at the number on your ID card. If your child has a behavioral health emergency, take your child to the nearest Emergency Room. You or someone on your child's behalf will need to call us at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar) and let us know your child had an emergency. Staff are available who speak both English and Spanish.

### Questions or Need Help Understanding / Reading Member Handbook?

We have staff who speak English and Spanish that can help you understand this handbook. We also have services for people who have a hard time reading, hearing, seeing, or speaking a language other than English or Spanish. You can ask for the Member Handbook in audio, other languages, Braille or larger print. If you need an audiocassette or CD, we will mail it to you. To get help, go to our website at [www.aetnamedicaid.com](http://www.aetnamedicaid.com) or call us at the toll-free number on your or your child's ID card.

# Member Services

## Member Services Department

We are available by phone Monday through Friday from 8 a.m. to 5 p.m. Call us at the toll free number on your or your child's ID card to:

- Ask questions about your/ your child's benefits and coverage.
- Change your/ your child's address or phone number.
- Change your/ your child's Primary Care Provider.
- Find out more about how to file a complaint.
- Call your/ your child's Primary Care Provider office with questions about appointments, hours or getting care after normal office hours.

## Plan Information and Resources Online

Get information 24 hours a day, 7 days a week on our website at [www.aetnamedicaid.com](http://www.aetnamedicaid.com). You can find information and answers to your questions without calling us.

The website allows you to:

- See member newsletters.
- See Questions and Answers about the CHIP program (including perinatal services).
- Search our provider directory to find Aetna doctors and hospitals in your area.
- Get information on different health topics.

## Eligibility and Benefits

Through Aetna Better Health<sup>sm</sup> we are pleased to offer you or your child all the benefits offered in the State of Texas's Children's Health Insurance Program (or "CHIP") *plus* expanded and value-added benefits. Information on eligibility and benefits are included in this Member Handbook. You picked your/ your child's doctor or clinic when you join Aetna Better Health. This doctor or clinic you picked is your/ your child's Primary Care Provider and will act as the gateway to care for all your child's healthcare needs.

Here are a few important things you need to do to help us give you or your children the best care:

- Check the ID card to make sure the information is correct. Your/ your child's Primary Care Provider's name will appear on your child's Aetna Better Health Card.
- Make any necessary appointments and become familiar with you or your child's Primary Care Provider
- Call your/ your children's Primary Care Provider for appointments and tell them you or your son or daughter is an Aetna Better Health member.
- Call the Primary Care Provider when you or your child needs care.
- Follow the Primary Care Provider's advice.
- Carry your/ your child's Aetna Better Health ID card with you at all times.
- Use the hospital Emergency Room (ER) **only** for emergencies.

## Member Handbook

This member handbook is subdivided into two sections for the CHIP Program Descriptions, benefits, etc:

- **CHIP / CHIP Perinate Newborn (pg. 1)**
- **CHIP Perinate (p. 36)**

# Aetna Better Health Privacy Notice

This privacy notice tells you how your health information may be used and shared. It also tells what you need to do to see it. Please read this letter closely. Please call us if you have any questions about this notice.

## **What do we do with your health information?**

We sometimes need to see your health information to answer your questions.

**Help take care of you:** We may use your health information to help with your health care. We also use it to decide what services your benefits cover. We may tell you about services you can get. This could be shots, checkups, or medical tests. We may also remind you of appointments.

We may share your health information with other people who give you care. This could be doctors, hospitals, drug stores, and others. We may have an internet website where doctors and the others who give you care can look at your health information. If you are no longer with our plan, with your okay, we will give your health information to your new doctor.

**Family and friends:** We may give out your health information to your family or friend who is helping you with your care or helping pay for your care. Example: if you have an accident, we may need to talk with one of these people. Please tell us if you do not want us to give your health information to your family or friend. Our address and phone number are at the end of this letter.

**For payment:** We may give your health information to others who pay for your care. Your doctor must give a claim form to us that contains your health information. We may also use your health information to go over the care your doctor gives you. We can also check your use of health services.

**Health care operations:** We may use your health information to help us do our job. We may use your health information for:

- Health promotion and disease prevention
- Quality improvement
- Insurance administration
- Case management
- Accounting and audits
- Business management and planning
- Legal matters
- Fraud prevention

A case manager may work with your doctor or others who give you care. The case manager may tell you about programs or places that can help you with your health problem.

**Public purposes:** We may use or give out your health information for some public reasons. Such as:

- *Required by law:* Federal, state, or local laws sometimes need us to give your health information to others.
  - For workers' compensation if you get hurt on the job
- *Public safety:* We may give out your health information for public safety and police purposes.
  - If they give us a search warrant or a grand jury witness request
  - To help them name or find someone
  - To stop harm to someone
  - For other reasons
- *Research:* We may use your health information for research. We will ask for your okay before we do this. We will make sure that no one will know it is your health information.
- *Oversight:* We can be checked by state and federal agencies to make sure your doctors are doing a good job and we are doing a good job. When these agencies do their checks, they may ask for our members' information and we must let them see our members' information.
- *Disputes:* We may give out your health information if it is required in a lawsuit or legal matter.

**Drug or Alcohol Information:** We may have information about your treatment for drug or alcohol addiction. We will not share this information with others except with your consent, if needed in a medical emergency or if required by law or a court.

**Uses of your information:** By joining the plan, you let us use your health information for the reasons we have described in this letter.

## **What are your rights?**

### **Right to see your health information:**

- You have the right to look at your health information and to get a copy of it. To get a copy of your health information, write to us at the address at the end of this letter.
- You can ask for your medical records. Call your doctor's office or the health care facility where you were treated to get a copy of these records.

### **Right to ask for a change to your information:**

- If you look at your information and see that something is not right, you can ask us to change it.
- To ask us to change your information, please write to us at the address at the end of this letter. You must clearly tell us what you want to change.

### **Right to get a list of people or groups that have a copy of your health information:**

- You have the right to get a list of the people and groups that we gave your health information to.
- If you want to get that list, please write to us at the address at the end of this letter.

### **Right to ask for a safe way to be in touch with you:**

- If you think the way we keep in touch with you is unsafe, please let us know. We will do our best to be in touch with you in a way that is more private.

### **Right to ask for special care for your health information:**

- We may use your health information in the ways we talked about in this letter.
- You can ask us not to use your information in these ways.
- We are not required to agree to this, but we will think about it carefully.
- If we do agree to how you want us to use your health information, we will tell you.
- If you want to ask for this change, please write to us at the address at the end of this letter.

### **Right to get a paper copy of this letter:**

- You have the right to a paper copy of this letter.
- To get a copy of this letter, visit our website at [www.aetnamedicaid.com](http://www.aetnamedicaid.com)
- You can also ask for a copy. Write to us at the address at the end of this letter. We will mail you a copy.

### **Will we change this letter?**

By law, we must keep private your health information. We must follow what we say in this letter. We also have the right to change this letter. If we change this letter, the changes apply to all of your information we have or will get in the future. You can get a copy of the most recent letter on our website at [www.aetnamedicaid.com](http://www.aetnamedicaid.com)

### **What if you have questions?**

If you have any questions about this notice or about how we use or share information, please contact Aetna Better Health Member Services at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar). Our office is open Monday through Friday from 8:00 a.m. to 5:00 p.m. You may also write us at:

Aetna Better Health  
PO Box 569150  
Dallas, TX 75356-9150

If you feel that your privacy rights – as explained in this Notice – have been violated, you may complain to Aetna Better Health or to the Secretary of Health & Human Services through the Office for Civil Rights (OCR). In order to file a complaint, please contact Member Services or you may contact Aetna Better Health's Privacy Officer.

Please remember that we will not take any action against you for filing a complaint. This is one of your rights. If our investigation of your complaint confirms that there has been a breach of your privacy through the actions of one of our employees or contractors, we will take disciplinary action against the employee or contractor who has caused the violation.

## About Your Child's Plan

As a member of Aetna Better Health, you can ask for and receive the following information for your child:

- Names, addresses, phone numbers, and languages spoken (other than English) by our network doctors, and identification of doctors that are not accepting new patients. The information given will be on primary care doctors, specialists and hospitals in your service area.
- Any limits on your freedom of choice among our network doctors for your child.
- Member rights and responsibilities.
- Information on complaint, appeal and independent review procedures.
- The amount, duration, and scope of benefits available under the contract will ensure that you know your child's benefits.
- How to get benefits including authorization requirements for your child.
- How you can get benefits, including from out-of-network doctors and/or limits to those benefits.
- How after hours and emergency coverages are given and limits to those benefits, including:
  - What makes up an emergency medical condition emergency services and post-stabilization services
  - The fact that prior authorization is not needed for emergency care services
  - How to get emergency services, including use of the 911 phone
  - The locations of any emergency settings and other locations at which doctors and hospitals provide emergency services covered under the contract
  - Your right to use any hospital or other settings for emergency care for your child
  - Post-stabilization rules
- Policy on referrals for specialty care and for other benefits not given by your child's Primary Care Provider.
- Aetna Better Health's practice guidelines.

### Certificate of Credible Coverage

If you need proof of your child's CHIP coverage to help you enroll your child with another insurance plan, please call us at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar). You can also write to:

Aetna Better Health  
Attention: Member Advocate  
PO Box 569150  
Dallas, Texas 75356-9150

We will be happy to give you with a certificate of credible coverage upon request.

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# Your CHIP/ CHIP Perinate Newborn Member Handbook

This handbook is a guide to help you know your/ your child's Aetna Better Health plan.

If you have questions about your/ your child's benefits or what is covered, please refer to the benefits section.

If you cannot find the answer to your question(s) in this handbook, use our website [www.aetnamedicaid.com](http://www.aetnamedicaid.com), or call us at the toll-free number on your/ your child's ID card. We will be happy to help you. To learn more about us, turn to page iii.

## Tips for members

1. Keep this handbook and any additional handbook information for future use.
2. Write your/ your child's ID number(s) in the front of this book or other safe place.
3. Always carry your/ your child's ID card with you.
4. Keep your/ your child's Primary Care Provider's name and number near the phone.
5. Use the Hospital Emergency Room (ER) only for emergencies.

## How Your/ Your Child's Plan Works

### The Basics

- You pick a primary care provider from our large list of doctors for you or your child. You can pick a different Primary Care Provider for each child in your family.
- You take your child to his/her Primary Care Provider for routine and preventive care or when other care is needed, such as for an illness or injury.
- Your/ your child's Primary Care Provider will send you to a specialist or coordinate care when needed.
- You pay copayments for certain medical services at the time of your/ your child's doctor visit.
- Your/ Your child has coverage in an emergency.


### Health Plan ID Card

When you or your child is enrolled with us, you or your child will get an ID card from us. The ID card lists the name and phone number(s) of your/ your child's Primary Care Provider. It will show co-payment information, if you have to pay for services. The back of the ID card has important phone numbers for you to call if you need help. Please make sure your/ your child's information on his/her ID card is correct.

Always carry your/ your child's ID card with you when going to see the doctor. You will need it to get health care for you or your child. You must show it each time you or your child gets services.

You or your child will not get a new ID card every month. If you call us to change your/ your child's Primary Care Provider or if your/ your child's copay changes, you or your child will get a new ID card. If your/ your child's card is lost or stolen, please call our Member Services Department right away so we can send you another ID card.

# Example of an Aetna Better Health CHIP ID Card

	Children's Health Insurance Program TDI
	<b>Attention Provider You Must Call 1-800-245-5380 For Pre-certification Or Case Management</b>

Member Services / Servicios para Miembros: **1-800-245-5380**  
 Behavioral Health/Salud Mental: **1-800-245-5380**  
 24 hours / 7 days per week /  
 24 horas del día/siete días de la semana  
 Informed Health Line/ Línea de salud informada: **1-800-556-1555**  
 Block Vision of Texas, Inc. Services line / Línea de Servicios para  
 Miembros de Block Vision of Texas, Inc.: **1-800-879-6901**  
 Relay Texas TTY: **1-800-735-2989**

<b>Pharmacy Coverage</b> RxBIN 610591 RxPCN ADV RxGRP R0801  <b>Pharmacist Use Only</b> <b>1.877.874.3317</b>
---

MEMBER NAME:  
 MEMBER ID:  
 EFF. DATE:  
 PCP: PCP TEL:  
 PCP EFFECTIVE DATE:  
 Doctor's Office Visit:  
 Emergency Room: Hospital Inpatient:  
 Prescription Generic Drugs: Hospital Outpatient:  
 Prescription Brand Drugs:  
**No copayments apply for well child or well baby immunization visits.**

MEMBER NOMBRE:  
 MEMBER ID:  
 EFECTIVO:  
 PCP: PCP TELE:  
 FECHA DE EFECTIVIDAD CON EL PCP:  
 Visita Oficina del Doctor:  
 Sala de emergencia: Paciente internado:  
 Medicamentos genéricos de receta: Paciente afuera del hospital:  
 Medicamentos de receta de marca:  
**Co-pagos no se aplican para exámenes bien o de niño visitas para vacunas.**

**Directions for What to Do In An Emergency**

In case of emergency call 911 or go to the closest emergency room. After treatment, call your child's PCP within 24 hours or as soon as possible.

For additional information regarding emergency services, please refer to your member handbook.

*In case of an emergency, please call 911*

**Instrucciones en caso de emergencia.**

En caso de emergencia, llama al 911 o vaya a la sala de emergencia más cercana. Después de recibir tratamiento, llame al PCP de su hijo dentro de 24 horas o tan pronto como sea posible.

Para más información sobre servicios de emergencia, avor de referirse al Manual para Miembros.

*En caso de una emergencia, por favor llama al 911*

Mail claims to this address:  
 Claims Processing Center  
 P.O. Box 60938  
 Phoenix, AZ 85082  
 Payor ID: 38692

Envíe reclamaciones a este dirección.  
 Claims Processing Center  
 P.O. Box 60938  
 Phoenix, AZ 85082  
 Payor ID: 38692

# Example of an Aetna Better Health CHIP Perinate Newborn ID Card

	<b>Children's Health Insurance Program</b>	TDI
<b>Attention: Provider You Must Call 1-800-245-5380 For Precertification Or Case Management</b>		

MEMBER NAME:  
MEMBER ID:  
EFF. DATE:

Member Services / Servicios para Miembros: **1-800-245-5380**  
Behavioral Health/Salud Mental: **1-800-245-5380**  
24 hours / 7 days per week /  
24 horas del día/siete días de la semana  
Informed Health Line/ Línea de salud informada: **1-800-556-1555**  
Block Vision of Texas, Inc.: Services line / Línea de Servicios para  
Miembros de Block Vision of Texas, Inc.: **1-800-879-6901**  
Relay Texas TTY: **1-800-735-2989**

MEMBER NOMBRE:  
MEMBER ID:  
EFFECTIVO:

<b>Pharmacy Coverage</b>
RxBIN 610691
RxPCN ADV
RxGRP Rx#001
<b>Pharmacist Use Only</b>
<b>1.877.874.3377</b>

## Co-pays do not apply.

### Directions for What to Do In An Emergency

In case of emergency call 911 or go to the closest emergency room.

*In case of an emergency, please call 911*

For additional information regarding emergency services, please refer to your member handbook.

Mail claims to this address:  
Claims Processing Center  
P.O. Box 60938  
Phoenix, AZ 85062  
Payor ID: 38692

## Co-pagos no se aplica.

### Instrucciones en caso de emergencia.

En caso de emergencia, llama al 911 o vaya a la sala de emergencia más cercana.

*En caso de una emergencia, por favor llama al 911*

Para más información sobre servicios de emergencia, avor de referirse al Manual para Miembros.

Envíe reclamaciones a este dirección.  
Claims Processing Center  
P.O. Box 60938  
Phoenix, AZ 85062  
Payor ID: 38692

# Primary Care Provider Information

References to “you,” “my,” or “I” apply if you are a CHIP Member. References to “my child” apply if your child is a CHIP Member or a CHIP Perinate Newborn Member.

## Role of the Primary Care Provider

### ***What is a Primary Care Provider?***

A Primary Care Provider is your/ your child's primary healthcare provider. Your/ your child's Primary Care Provider will give or arrange for all the medical care you or your child needs. Your/ your child's Primary Care Provider can take care of routine medical problems. Sometimes you or your child might have a problem that needs to be handled by a specialist. The Primary Care Provider can arrange to have you or your child see the right specialist. The Primary Care Provider will approve you or your child to see the specialist with a referral and tell you how to make an appointment. If you or your child needs to be admitted to a hospital, your Primary Care Provider can arrange that for you or your child.

Our goal is your/ your child's good health. We urge you or your child to see the Primary Care Provider to get preventive care services within the next sixty (60) days or as soon as possible. This will help your doctor learn about you or your child so he or she can help you plan for you or your child's future health care needs. Getting started with your doctor can also help prevent delays in care when you or your child is sick.

Remember, you and the Primary Care Provider are the most important members of your/ your child's health care team.

## Choosing Your/ Your Child's Primary Care Provider

### ***Can a Clinic Be My/ My Child's Primary Care Provider?***

Your/ your child's Primary Care Provider can be a clinic. Some of the doctors that you can also pick from to be your/ your child's Primary Care Providers are: family doctors; pediatricians (for children); OB/Gyns (woman's doctor); general practitioners (GPs); advanced nurse practitioners (ANPs); Federally Qualified Health Clinics (FQHCs); and Rural Health Clinics (RHCs).

Please look at our Provider Directory to get more information on Primary Care Providers. You must pick a Primary Care Provider for you or your child who is in our network. You can get a copy of the directory on [www.aetnamedicaid.com](http://www.aetnamedicaid.com) or by calling us at the toll-free number listed on your/ your child's ID card.

You/your child can keep seeing his/her current Primary Care Provider if the Primary Care Provider is listed in our Provider Directory. There are times when we might let a specialist be your/ your child's Primary Care Provider.

## Visiting Your/ Your Child's Primary Care Provider

### ***What Do I Need To Bring with Me to My/ My Child's Doctor's Appointment?***

You should take the following items with you when you go to your/ your child's doctor's appointment:

- ID card
- Immunization (shot) records, and
- Paper to take notes on information you get from the doctor.

## What If I Choose to Take My Child to Another Doctor Who Is Not My/ My Child's Primary Care Provider?

You will need to go to your/ your child's Primary Care Provider for most health services or you might have to pay for the services.

## ***What Type of Care Does Not Require My/ My Child to First Be Seen by Primary Care Provider?***

For the following types of care, you do not have to go to your/ your child's Primary Care Provider first:

- Emergency
- OB/GYN
- Behavioral Health
- Routine Eye Care
- Texas Health Steps Medical and Dental Checkups

To learn more, please look at our website [www.aetnamedicaid.com](http://www.aetnamedicaid.com) or call us at the toll-free number on your/ your child's ID card.

## **Changing Your/ Your Child's Primary Care Provider**

### ***How Can I Change My/ My Child's Primary Care Provider?***

You can change your/ your child's Primary Care Provider by calling us at the toll-free number on your/ your child's ID card. For a list of doctors and clinics, please see our Provider Directory. You can view this online at [www.aetnamedicaid.com](http://www.aetnamedicaid.com).

### ***How Many Times Can I Change My/ My Child's Primary Care Provider?***

There is no limit on how many times you can change your/your child's primary care provider. You can change primary care providers by calling us toll-free at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar) or writing to:

#### **Aetna Better Health**

Attention: Aetna Better Health Member Services  
PO Box 569150  
Dallas, TX 75356-9150

### ***When Will A Primary Care Provider Change Become Effective?***

If you change your/ your child's Primary Care Provider, you or your child will receive a new ID card. The new ID card will tell you the new Primary Care Provider's name, address, phone number and date your/ your child's new Primary Care Provider will be effective. The Primary Care Provider change will become effective the same day that you call us to change your/ your child's Primary Care Provider.

### ***Are There Any Reasons Why A Request to Change a Primary Care Provider May Be Denied?***

In some cases, your request to change your/ your child's Primary Care Provider can be denied. Your request can be denied if:

- The Primary Care Provider you picked for you or your child is not accepting new patients.
- The Primary Care Provider you picked for you or your child is no longer a part of our Health Plan.

### ***Can a Primary Care Provider Move Me or My Child to Another Primary Care Provider for Non-Compliance?***

A Primary Care Provider can request that you or your child pick a new Primary Care Provider for the following reasons:

- You or your child often misses appointments and you have not called to let the Primary Care Provider know.
- You do not follow advice from your/ your child's Primary Care Provider.

### ***What If My/ My Child's Primary Care Provider Leaves the Aetna Better Health Network?***

If your/ your child's doctor leaves our network, we will send you a letter telling you the new Primary Care Provider we have chosen for you or your child. If you are not happy with the new Primary Care Provider, call us at the toll-free number on your/ your child's ID card and tell us the Primary Care Provider you want. If you or your child is getting medically necessary treatments, you or your child will be able to stay with that doctor if he or she is willing to see you or your child. When we find a new Primary Care Provider on our list who can give you or your child the same type of care, we will change your/ your child's Primary Care Provider.

## After Hours Care

### ***How Do I Get Medical Care After My/ My Child's Primary Care Provider's Office is Closed?***

If you or your child gets sick at night or on a weekend and cannot wait to get medical care, call your/your child's Primary Care Provider for advice. Your/ your child's Primary Care Provider or another doctor is ready to help by phone 24 hours a day, 7 days a week. You may also call the 24-hour Informed Health Line<sup>®</sup> at 1-800-556-1555 to speak with a registered nurse to help you decide what to do.

## Physician Incentive Plan Information

A physician incentive plan rewards doctors for treatments that reduce or limit services for people covered by CHIP. Right now, Aetna Better Health does not have a physician incentive plan.

## Health Plan Information

### Changing Your or Your Child's Health Plan

#### ***What If I Want to Change Health Plans? Who Do I Call?***

You are allowed to make health plan changes:

- For any reason within 90 days of enrollment in CHIP;
- for cause at any time;
- during the annual CHIP re-enrollment period.

For more information, call CHIP toll-free at 1-800-647-6558.

#### ***How Many Times Can I Change Health Plans?***

There is no limit on how many times you can change health plans.

#### ***When will my Health Plan Change Become Effective?***

If you call to change your health plan on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15<sup>th</sup> of the month, the change will take place the first day of the second month after that. For example:

- If you call on or before April 15, your change will take place on May 1.
- If you call after April 15, your change will take place on June 1.

#### ***Can Aetna Better Health Ask That I Get Dropped from Their Health Plan for Non-Compliance, etc?***

You or your child can be disenrolled from our plan if:

- You or your child turns nineteen.
- You do not re-enroll yourself or your child at the end of the 12-month eligibility period.
- You or your child permanently moves out of the service area.
- You or your child becomes enrolled in another health plan or has a change in health insurance status (i.e. coverage by employer insurance).
- You keep taking yourself or your child to the ER when you or your child does not have an emergency.
- You keep taking yourself or your child to another doctor or clinic without first getting approval from your/ your child's Primary Care Provider.
- You or your children show a pattern of disruptive or abusive behavior not related to a medical condition.
- You or your child misses many visits without letting your/ your child's doctor know in advance.
- You let someone else use your/ your child's ID card.
- You often do not follow your/ your child's doctor's advice.

## Benefits

References to “you,” “my,” or “I” apply if you are a CHIP Member. References to “my child” or “my daughter” apply if your child is a CHIP Member.

### What are my CHIP Benefits?

There is no lifetime maximum on benefits; however, a 12-month period or lifetime limitations do apply to certain services, as specified in the following chart. Copays apply until a family reaches its specific cost-sharing maximum.

#### How do I get these services/ how do I get these services for my child?

You should see your/ your child’s Primary Care Provider to ask about medical services. To learn more about how to obtain these or other services, please use the website ([www.aetnamedicaid.com](http://www.aetnamedicaid.com)) or call us at the toll-free number on your/ your child’s ID card.

#### Are there any limits to any covered services?

There is no lifetime maximum on benefits; however, 12-month period or lifetime limitations do apply to certain services, as specified in the following chart.

### What are the CHIP Perinatal Benefits?

Aetna Better Health provides CHIP Perinatal benefits as outlined below. There is no lifetime maximum on benefits; however, 12-month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart.

**Copays do not apply to the Aetna Better Health CHIP Perinate Newborn members.**

#### How Do I Get These Services for My Child?

You should see your child’s Primary Care Provider to ask about medical services. To learn more about how to obtain these or other services, please use the website ([www.aetnamedicaid.com](http://www.aetnamedicaid.com)) or call us at the toll-free number on your child’s ID card.

#### What Benefits Does My Baby Receive At Birth?

Your baby will receive the same benefits as all other the CHIP members, except there are no co-pays while on CHIP Perinatal

### Schedule of Benefits

Aetna Better Health provides CHIP services as outlined below. There is no lifetime maximum on benefits; however, 12-month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart.

Type of Benefit	Description of Benefit	Limitations	Copay
<b>Inpatient General Acute and Inpatient Rehabilitation Hospital Services</b>	<p>Services include:</p> <ul style="list-style-type: none"> <li>▪ Hospital-provided physician or provider services</li> <li>▪ Semi-private room and board (or private if medically necessary as certified by attending)</li> <li>▪ General nursing care</li> <li>▪ Special duty nursing when medically necessary</li> <li>▪ ICU and services</li> <li>▪ Patient meals and special diets</li> <li>▪ Operating, recovery and other treatment rooms</li> <li>▪ Anesthesia and administration (facility technical component)</li> <li>▪ Surgical dressings, trays, casts, splints</li> <li>▪ Drugs, medications and biologicals</li> <li>▪ Blood or blood products that are not provided free-of-charge to the patient and their administration,</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>For Aetna Better Health CHIP Perinate Newborns</b> in families with incomes at or below 185% of the Federal Poverty Level (FPL) the facility charges are not a covered benefit for the initial Perinate Newborn admission. Facility charges are a covered benefit after the initial Perinate Newborn admission.</li> <li>▪ <b>For Aetna Better Health CHIP Perinate Newborns</b> in families with incomes at or below 185% of the the Federal Poverty Level (FPL), professional service charges are a covered benefit for the initial Perinate Newborn admission and subsequent admissions.</li> </ul>	<p>Applicable level of inpatient co-pay applies for CHIP Members,</p> <p><b>No co-pays required for CHIP Perinate Newborn Members.</b></p>

Type of Benefit	Description of Benefit	Limitations	Copay
	<ul style="list-style-type: none"> <li>▪ X-rays, imaging and other radiological tests (facility technical component)</li> <li>▪ Laboratory and pathology services (facility technical component)</li> <li>▪ Machine diagnostic tests (EEGs, EKGs, etc)</li> <li>▪ Oxygen services and inhalation therapy</li> <li>▪ Radiation and chemotherapy</li> <li>▪ Access to DSHS-designated Level III perinatal centers or hospitals meeting equivalent levels of care</li> <li>▪ In-network or out-of-network facility and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section</li> <li>▪ Hospital, physician and related medical services, such as anesthesia, associated with dental care.</li> <li>▪ Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: <ul style="list-style-type: none"> <li>▪ dilation and curettage (D&amp;C) procedures;</li> <li>▪ appropriate provider-administered medications;</li> <li>▪ ultrasounds; and</li> <li>▪ histological examination of tissue samples.</li> </ul> </li> <li>▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as a part of a proposed and clearly outlined treatment plan to treat: <ul style="list-style-type: none"> <li>- cleft lip and/or palate; or</li> <li>- severe traumatic skeletal and/or congenital craniofacial deviations; or</li> <li>- severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.</li> </ul> </li> <li>▪ Surgical implants</li> <li>▪ Other artificial aids including</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires prior authorization for non-emergency care and following stabilization of an emergency condition</li> <li>▪ Requires prior authorization for in-network or out-of-network facility for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by caesarian section</li> </ul>	

Type of Benefit	Description of Benefit	Limitations	Copay
	<p>surgical implants</p> <ul style="list-style-type: none"> <li>▪ Inpatient services for a mastectomy and breast reconstruction include: <ul style="list-style-type: none"> <li>- all stages of reconstruction on the affected breast;</li> <li>- surgery and reconstruction on the other breast to produce symmetrical appearance; and</li> <li>- treatment of physical complications from the mastectomy and treatment of lymphedemas.</li> </ul> </li> <li>▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12 month period limit</li> </ul>		
<b>Transplants</b>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>▪ Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires authorization</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>No co-pays required for CHIP or CHIP Perinate Newborn Members</b></li> </ul>
<b>Skilled Nursing Facilities (Includes Rehabilitation Hospitals)</b>	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>▪ Semi-private room and board</li> <li>▪ Regular nursing services</li> <li>▪ Rehabilitation services</li> <li>▪ Medical supplies and use of appliances and equipment furnished by the facility</li> </ul>	<ul style="list-style-type: none"> <li>• Requires authorization and physician prescription</li> <li>▪ 60 days per 12-month period limit</li> </ul>	<ul style="list-style-type: none"> <li>• <b>No co-pays required for CHIP or CHIP Perinate Newborn Members</b></li> </ul>
<b>Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center</b>	<p>Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:</p> <ul style="list-style-type: none"> <li>▪ X-ray, imaging, and radiological tests (technical component)</li> <li>▪ Laboratory and pathology services (technical component)</li> <li>▪ Machine diagnostic tests</li> <li>▪ Ambulatory surgical facility services</li> <li>▪ Drugs, medications and biologicals</li> <li>▪ Casts, splints, dressings</li> <li>▪ Preventive health services</li> <li>▪ Physical, occupational and speech therapy</li> <li>▪ Renal dialysis</li> <li>▪ Respiratory services</li> <li>▪ Radiation and chemotherapy</li> <li>▪ Blood or blood products not provided free of charge to the patient and the</li> </ul>	<ul style="list-style-type: none"> <li>▪ May require prior authorization and physician prescription</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable level of copay applies to prescription drug services for CHIP Members.</li> <li>▪ <b>No co-pays required for CHIP Perinate Newborn Members.</b></li> </ul>

Type of Benefit	Description of Benefit	Limitations	Copay
	<p>administration of these products</p> <ul style="list-style-type: none"> <li>▪ Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility.</li> <li>▪ Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: <ul style="list-style-type: none"> <li>▪ dilation and curettage (D&amp;C) procedures;</li> <li>▪ appropriate provider-administered medications;</li> <li>▪ ultrasounds; and</li> <li>▪ histological examination of tissue samples.</li> </ul> </li> <li>▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: <ul style="list-style-type: none"> <li>- cleft lip and/or palate; or</li> <li>- severe traumatic skeletal and/or congenital craniofacial deviations; or</li> <li>- severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.</li> </ul> </li> <li>▪ Surgical implants</li> <li>▪ Other artificial aids including surgical implants</li> <li>▪ Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate include: <ul style="list-style-type: none"> <li>- all stages of reconstruction on the affected breast;</li> <li>- surgery and reconstruction on the other breast to produce symmetrical appearance; and</li> <li>- treatment of physical complications from the mastectomy and treatment of lymphedemas.</li> </ul> </li> <li>▪ Implantable devices are covered under Inpatient and Outpatient</li> </ul>		

Type of Benefit	Description of Benefit	Limitations	Copay
	services and do not count towards the DME 12 month period limit		
<b>Physician/Physician Extender Professional Services</b>	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>▪ American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations)</li> <li>▪ Physician office visits, inpatient and outpatient services</li> <li>▪ Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation</li> <li>▪ Medications, biologicals and materials administered in physician's office</li> <li>▪ Allergy testing, serum and injections</li> <li>▪ Professional component (in/outpatient) of surgical services, including: <ul style="list-style-type: none"> <li>• Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care</li> <li>• Administration of anesthesia by physician (other than surgeon) or CRNA</li> <li>• Second surgical opinions</li> <li>• Same-day surgery performed in a hospital without an over-night stay</li> <li>• Invasive diagnostic procedures such as endoscopic examination</li> </ul> </li> <li>▪ Hospital-based physician services</li> <li>▪ (including physician-performed technical and interpretative components)</li> <li>▪ Physician and professional services for a mastectomy and breast reconstruction include: <ul style="list-style-type: none"> <li>- all stages of reconstruction on the affected breast;</li> <li>- surgery and reconstruction on the other breast to produce symmetrical appearance; and</li> <li>- treatment of physical complications from the mastectomy and treatment of lymphedemas.</li> </ul> </li> <li>▪ In-network and out-of-network physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours</li> </ul>	<ul style="list-style-type: none"> <li>▪ May require an authorization for specialty referral from a PCP to an in-network specialist.</li> <li>▪ Requires authorization for all out-of-network specialty referrals.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable level of copay applies to office visits for CHIP Members.</li> <li>▪ <b>No co-pays required for CHIP Perinate Newborn Members.</b></li> </ul>

Type of Benefit	Description of Benefit	Limitations	Copay
	<p>following an uncomplicated delivery by caesarian section</p> <ul style="list-style-type: none"> <li>▪ Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation.</li> <li>▪ Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to: <ul style="list-style-type: none"> <li>▪ dilation and curettage (D&amp;C) procedures;</li> <li>▪ appropriate provider-administered medications;</li> <li>▪ ultrasounds; and</li> <li>▪ histological examination of tissue samples.</li> </ul> </li> <li>▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: <ul style="list-style-type: none"> <li>- cleft lip and/or palate; or</li> <li>- severe traumatic skeletal and/or congenital craniofacial deviations; or</li> <li>- severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.</li> </ul> </li> </ul>		
<b>Birthing Center Services</b>	<b>CHIP only</b> - Covers birthing services provided by a licensed birthing center	<ul style="list-style-type: none"> <li>▪ Limited to facility services (e.g. labor and delivery).</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>No co-pays required for CHIP Members</b></li> </ul>
<b>Services rendered by a Certified Nurse Midwife or physician in a licensed birthing center</b>	<p><b>CHIP</b> - Covers prenatal, birthing, and postpartum services rendered in a licensed birthing center.</p> <p><b>CHIP Perinate Newborn</b> – Covers services rendered to a newborn immediately following delivery.</p>		<ul style="list-style-type: none"> <li>▪ <b>No co-pays required for CHIP or CHIP Perinate Newborn Members</b></li> </ul>
<b>Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies</b>	Covered services include DME (equipment which can withstand repeated use, and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness , injury	<ul style="list-style-type: none"> <li>▪ May require prior authorization and physician prescription</li> <li>▪ \$20,000 12-month period limit for DME, prosthetics, devices</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>No co-pays required for CHIP or CHIP Perinate Newborn Members</b></li> </ul>

Type of Benefit	Description of Benefit	Limitations	Copay
	<p>or disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living, and appropriate to assist in the treatment of a medical condition, including, but not limited to:</p> <ul style="list-style-type: none"> <li>▪ Orthotic braces and orthotics</li> <li>▪ Dental devices</li> <li>▪ Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses.</li> <li>▪ Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease</li> <li>▪ Other artificial aids including surgical implants</li> <li>▪ Hearing aids</li> <li>▪ Other artificial aids</li> <li>▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit.</li> <li>▪ Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formulas and dietary supplements</li> </ul>	<p>and disposable medical supplies (implantable devices, diabetic supplies and equipment are not counted against this cap)</p>	
<p><b>Home and Community Health Services</b></p>	<p>Services that are provided in the home and community, including, but not limited to:</p> <ul style="list-style-type: none"> <li>▪ Home infusion</li> <li>▪ Respiratory therapy</li> <li>▪ Visits for private duty nursing (R.N., L.V.N.)</li> <li>▪ Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.).</li> <li>▪ Home health aide when included as part of a plan of care during a period that skilled visits have been approved</li> <li>▪ Speech, physical and occupational therapies.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires authorization and physician prescription</li> <li>▪ Services are not intended to replace the child's caretaker or to provide relief for the caretaker</li> <li>▪ Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services</li> <li>▪ Services are not intended to replace 24-hour inpatient or skilled nursing facility services</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>No co-pays required for CHIP or CHIP Perinate Newborn Members</b></li> </ul>
<p><b>Inpatient Mental Health Services</b></p>	<p>Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state operated facilities, including but not limited to:</p> <ul style="list-style-type: none"> <li>▪ Neuropsychological and psychological testing.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires prior authorization for non-emergency services.</li> <li>▪ Does not require PCP referral.</li> <li>▪ When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable level of inpatient co-pay applies for CHIP members.</li> <li>▪ <b>No co-pays required for CHIP Perinate Newborn Members.</b></li> </ul>

Type of Benefit	Description of Benefit	Limitations	Copay
		<p>and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.</p>	
<p><b>Outpatient Mental Health Services</b></p>	<p>Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to:</p> <ul style="list-style-type: none"> <li>▪ The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility</li> <li>▪ Neuropsychological and psychological testing.</li> <li>▪ Medication management</li> <li>▪ Rehabilitative day treatments</li> <li>▪ Residential treatment services</li> <li>▪ Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment)</li> <li>▪ Skills training (psycho-educational skill development)</li> </ul>	<ul style="list-style-type: none"> <li>▪ May require prior authorization.</li> <li>▪ Does not require PCP referral.</li> <li>▪ When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.</li> <li>▪ A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1), §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (that can be</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable level of copay applies to office visits for CHIP Members.</li> <li>▪ <b>No co-pays required for CHIP Perinate Newborn Members.</b></li> </ul>

Type of Benefit	Description of Benefit	Limitations	Copay
		components of interventions such as day treatment and in-home services), patient and family education, and crisis services.	
<b>Inpatient Substance Abuse Treatment Services</b>	<p>Inpatient substance abuse treatment services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>▪ Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires prior authorization for non-emergency services</li> <li>▪ Does not require Primary Care Provider referral.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable level of inpatient co-pay applies to CHIP Members.</li> <li>▪ <b>No co-pays required for CHIP Perinate Newborn Members.</b></li> </ul>
<b>Outpatient Substance Abuse Treatment Services</b>	<p>Outpatient substance abuse treatment services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>▪ Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders.</li> <li>▪ Intensive outpatient services</li> <li>▪ Partial hospitalization</li> <li>▪ Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training that consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day.</li> <li>▪ Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training.</li> </ul>	<ul style="list-style-type: none"> <li>▪ May require prior authorization.</li> <li>▪ Does not require Primary Care Provider referral.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable level of co-pay applies to office visits for CHIP Members.</li> <li>▪ <b>No co-pays required for CHIP Perinate Newborn Members.</b></li> </ul>
<b>Rehabilitation Services</b>	<p>Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>▪ Physical, occupational and speech therapy</li> <li>▪ Developmental assessment</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires prior authorization and physician prescription</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>No co-pays required for CHIP or CHIP Perinate Newborn Members</b></li> </ul>

Type of Benefit	Description of Benefit	Limitations	Copay
<b>Hospice Care Services</b>	<p>Services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>▪ Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death</li> <li>• Treatment for unrelated conditions is unaffected</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires authorization and physician prescription</li> <li>▪ Services apply to the hospice diagnosis</li> <li>▪ Up to a maximum of 120 days with a 6 month life expectancy</li> <li>• Patients electing hospice services may cancel this election at anytime</li> </ul>	<ul style="list-style-type: none"> <li>• <b>No co-pays required for CHIP or CHIP Perinate Newborn Members</b></li> </ul>
<b>Emergency Services, Including Emergency Hospital, Physicians, and Ambulance Services</b>	<p>Health plan cannot require authorization as a condition for payment for emergency conditions or labor and delivery.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>▪ Emergency services based on prudent lay person definition of emergency health condition</li> <li>▪ Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers</li> <li>▪ Medical screening examination</li> <li>▪ Stabilization services</li> <li>▪ Access to DSHS designated Level I and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services</li> <li>▪ Emergency ground, air or water transportation</li> <li>▪ Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Does not require authorization for post-stabilization services</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable co-pays apply to non-emergency ER for CHIP members.</li> <li>▪ <b>No co-pays required for CHIP Perinate Newborn Members.</b></li> </ul>
<b>Vision Benefit</b>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>▪ One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization</li> <li>▪ One pair of non-prosthetic eyewear per 12-month period</li> </ul>	<ul style="list-style-type: none"> <li>• The health plan may reasonably limit the cost of the frames/lenses.</li> <li>• Does not require authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye.</li> </ul>	<ul style="list-style-type: none"> <li>• Applicable level of copay applies to office visit for CHIP Members.</li> <li>• <b>No co-pays required for CHIP Perinate Newborn Members.</b></li> </ul>

Type of Benefit	Description of Benefit	Limitations	Copay
<b>Chiropractic Services</b>	<ul style="list-style-type: none"> <li>▪ Covered services do not require physician prescription and are limited to spinal subluxation</li> </ul>	<ul style="list-style-type: none"> <li>• Does not require authorization for twelve visits per 12-month period limit (regardless of number of services or modalities provided in one visit)</li> <li>• Does not require authorization for additional visits.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable level of copay applies to office visit for CHIP Members.</li> <li>▪ <b>No co-pays required for CHIP Perinate Newborn Members.</b></li> </ul>
<b>Tobacco Cessation Programs</b>	<ul style="list-style-type: none"> <li>▪ Covered up to \$100 for a 12-month period limit for a plan-approved program</li> </ul>	<ul style="list-style-type: none"> <li>• Does not require authorization</li> <li>• Health plan defines the plan-approved program.</li> <li>• May be subject to formulary requirements.</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>No co-pays required for CHIP or CHIP Perinate Newborn Members</b></li> </ul>

\* Co-payments do not apply to preventive services or pregnancy-related assistance.

### What Services are Not Covered?

Services that are not covered by CHIP and CHIP Perinate Newborns are called "Exclusions." The Exclusions are listed below.

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (.e. cannot be prescribed for family planning).
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles that are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical or other health care procedures or services that are not generally employed or recognized within the medical community. This exclusion is an adverse determination and is eligible for review by an Independent Review Organization.
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
- Dental devices solely for cosmetic purposes
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise preauthorized by the health plan
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Out-of-network services not authorized by the health plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the health plan
- Medications prescribed for weight loss or gain
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the member or the vendor

- Corrective orthopedic shoes
- Convenience items
- Over-the-counter medications
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice.
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, that do not require the skill and training of a nurse
- Vision training and vision therapy
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/Primary Care Provider
- Donor non-medical expenses
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan
- Coverage while traveling outside the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).

## Your Out-of-Pocket Costs

### ***How Much Do I Have to Pay for My/ My Child's Health Care?***

You might have to pay a copayment when you or your child gets certain covered services. See the copayment table below for a complete list of payable amounts. Your/ your child's ID card will list your copayment amount.

### ***What Are Copayments? How Much are They and When Do I Have to Pay Them?***

The table below lists the CHIP co-payment by the amount your family makes. Copayments are paid to the doctor or drug store at the time of service. No copayments are paid for well-child visits or immunizations. **Copayments do not apply to CHIP Perinate Newborn members.**

Your/ your child's ID card lists the copayments that you must pay. Show your/ your child's ID card when you have an office visit, go to the ER, or have a prescription filled.

## Co-payment Table

Federal Poverty Levels (FPLs)	Office Visits	Emergency Room Visits	Inpatient Hospital Stays	Prescription Drugs (Generic)	Prescription Drugs (Brand Name)	Annual Reporting Caps per Term of Coverage
<b>Native American and Alaskan Natives</b>	\$0	\$0	\$0	\$0	\$0	\$0
<b>At or Below 100%</b>	\$3	\$3	\$15	\$0	\$3	5% of family net income
<b>101%-150%</b>	\$5	\$5	\$35	\$0	\$5	5% of family net income
<b>151%-185%</b>	\$20	\$75	\$75	\$10	\$35	5% of family net income
<b>186%-200%</b>	\$25	\$75	\$125	\$10	\$35	5% of family net income

# Medications

## ***How Do I Get My/ My Child's Medications?***

CHIP covers most medicine your/ your child's doctor says you need. Your/ your child's doctor will write a prescription so you can take it to the drug store, or may be able to send the prescription for you.

Exclusions include: contraceptive medications prescribed only for the purpose to prevent pregnancy and medications for weight loss or gain.

You may have to pay a co-payment for each prescription filled depending on your income

## ***Who Do I Call If I Have Problems Getting My/ My Child's Medications?***

If you have a problem getting your medications, call us at the toll free number on your/ your child's ID card.

## ***What if I Can't Get The Medication My/ My Child's Doctor Ordered Approved?***

If your/ your child's doctor cannot be reached to approve a prescription, your child may be able to get a three day emergency supply of your/ your child's medication.

Call Aetna Better Health at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar) for help with your medications and refills.

## ***What If I Lose My/ My Child's Medication(s)?***

If you have lose your medications, call us at the toll free number on your/ your child's ID card.

## ***How Do I Find a Network Drug Store?***

You can find a network pharmacy in one of two ways.

- Visit our website at [www.aetnamedicaid.com](http://www.aetnamedicaid.com), and then search for a pharmacy in your area.
- Call Member Services toll-free at **1-800-359-5613**. Ask the representative to help you find a network pharmacy in your area.

## ***What If I Go To a Drug Store Not In the Network?***

Prescriptions filled at other pharmacies that are not in the Aetna Better Health network will not be covered. All prescriptions must be filled at a network pharmacy.

## ***What Do I Bring With Me To the Drug Store?***

You will need to bring the prescription your/ your child's doctor wrote for you or your child. You will also need to show your/ your child's Aetna Better Health Plan ID card.

## ***What If I Need My Medications Delivered To Me?***

If you/your child take medication for an ongoing health condition, you/ your child can have your medications mailed to your home. CVS Caremark is your mail service pharmacy.

If you choose this option, your medication comes right to your door. You can schedule your refills and reach pharmacists if you have questions. Here are some other features of home delivery.

- Pharmacists check each order for safety.
- You can order refills by mail, by phone, online, or you can sign up for automatic refills.
- You can talk with pharmacists by phone.

## ***It's easy to start using mail service***

Choose ONE of the following three ways to use mail service for a medication that you/ your child takes on an ongoing basis:

- Call the FastStart<sup>®</sup> toll-free number at 1-800-875-0867, Monday through Friday, 7 a.m. to 7 p.m. (CT). A representative will let you know which of your/ your child's prescriptions can be filled through

CVS Caremark Mail Service Pharmacy. CVS Caremark will then contact your/ your child's doctor for a prescription and mail the medication to you.

When you call, be sure to have:

- Your/ your child's Aetna Better Health member ID card
  - Your/ your child's doctor's first and last name and phone number
  - Your/ your child's payment information and mailing address
- Log on to [www.caremark.com/faststart](http://www.caremark.com/faststart). Going online is a quick and easy way to start using mail service. Once you provide the requested information, CVS Caremark will contact your/ your child's doctor for a new prescription. If you haven't registered yet on [www.caremark.com](http://www.caremark.com), be sure to have your/ your child's member ID card handy when you register for the first time.
- Fill out and send a mail service order form. If you already have a prescription, you can send it to CVS Caremark with a completed mail service order form. If you don't have an order form, you can print one online or you can request one by calling toll-free 1-855-271-6603.
- Please have the following information with you when you complete the form:
- Your/ your child's Aetna Better Health member ID card
  - Your/ your child's complete mailing address, including ZIP code
  - Your/ your child's doctor's first and last name and phone number
  - A list of your/ your child's allergies and other health conditions
  - Your credit or debit card number. You can also pay by check, electronic check, Bill Me Later®, or money order. For more information on copays, call us at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar).
  - Your original prescription from your/ your child's doctor.

If you/ your child needs your prescription filled right away, ask your doctor to write two prescriptions for your/ your child's long-term medication:

- One for a short-term supply (30 days or less) that can be filled at a participating network pharmacy AND
- One for the maximum days supply allowed by your plan, with refills as needed. Enclose this prescription along with the mail service order form.

***What if I Need/ My Child Needs an Over the Counter Medication for CHIP?***

The pharmacy cannot give you an over the counter medication as part of your/your child's CHIP benefit. If you need/ your child needs an over the counter medication, you will have to pay for it.

***What if I Need/ My Child Needs More than 34 Days of a Prescribed Medication?***

The pharmacy can only give you as much of a medication as you need/ your child needs for 34 days. For any other questions please call Aetna Better Health at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar).

***What If I Need/ My Child Needs Birth Control Pills?***

The pharmacy cannot give you/ your child birth control pills to prevent pregnancy. You/ your child can only get birth control pills if they are needed to treat a medical condition.

## **Vision Services**

***How Do I Get Eye Care Services For Myself/ My Child?***

Block Vision will provide vision services like exams and glasses. Block Vision will help you or your child's get the care he/she needs while coordinating with us.

If you or your child needs vision services, please call Block Vision at 1-800-879-6901.

## Dental Services

### ***How Do I Get Dental Services For My Child?***

Your child's CHIP dental plan provides dental services including services that help prevent tooth decay and services that fix dental problems. Call your child's CHIP dental plan to learn more about the services they offer.

Aetna Better Health offers emergency dental services your child gets in a hospital. This includes services the doctor provides and other services might need like anesthesia.

## Cost Sharing Limit

### ***What are Cost Sharing Caps?***

The Member Guide you got from us when you join the CHIP program has a form to help you track your CHIP expenses. To make sure that you do not go over your cost-sharing limit, please list CHIP expenses on this form. The welcome letter in the enrollment packet tells you when you can mail the form back to CHIP. If you lose your welcome letter, please call the **CHIP Help Line at 1-800-647-6558**. They will tell you what your cost-sharing limit is. There are no copayments required for CHIP Perinate Newborn members.

When you reach your yearly cap per term of coverage, please send the form to the CHIP Enrollment Broker and they will let us know. We will send a new member ID card. This new card will show that no copayments are due when your child gets services. If you need help understanding copayments, please go to our website at [www.aetnamedicaid.com](http://www.aetnamedicaid.com), or call us at the toll-free number listed on your/ your child's ID card.

## Provider Billing

### ***What If I Get a Bill from my Doctor? Who Do I Call? What Information Will They Need?***

As a parent or guardian, you must pay for the copayments for your child's care. If you feel that you should not have gotten a bill or you need help to understand the bill, call us at the toll-free number listed on your child's ID card. We will help explain the bill to you. We can talk to the doctor's office for you to explain your child's benefits. We can also help you arrange for the bill to be paid. When you call us, please have your child's ID card and the doctor's bill with you. We will need information so we can help you quickly.

## What Extra Benefits Does a Member of Aetna Better Health Get?

Aetna Better Health members get the following value-added services and extra benefits:

### **Value-added Services**

- **Informed Health Line** -1-800-556-1555 – You can talk to a nurse 24 hours a day, 7 days a week. The nurse can help you with questions or help you decide what to do about your health needs. Only your doctor can give medical advice or medicines. The Informed Health nurses can give information on over 5,000 health topics. Call your doctor first with any questions or concerns about your health care needs.
- **Sports Physical Exams** – Aetna Better Health members can get one sports physical exam per year.
- **Smoking Cessation Program** – Aetna Better Health will offer smoking cessation benefits including assessment and counseling to CHIP members 12 years of age and older. Nicotine replacement products to CHIP members 18 years of age and older unless prescribed by a doctor.
- **Weight Management Program** - Aetna Better Health will offer weight management programs including family counseling with a nutritionist/dietician for non-pregnant members 12-19 years old.
- **Contact Lenses Program** – Aetna Better Health will offer a benefit for contact lenses, including a fitting exam, with additional benefits to be applied towards the purchase of contact lenses to correct vision for members 12-18 years old.

**Extra Benefits**

- Free Member Newsletter – You will get a newsletter in the mail with information on health topics to help your child.
- Case Management and Disease Management - Nurses give you information about your child’s health concerns and help coordinate services for those members who have chronic or complex illnesses.

**How Can I Get These Benefits for Myself or My Child?**

You do not have to go to your/ your child’s Primary Care Provider to get these services. If you have questions or need help with these services, visit the website ([www.aetnamedicaid.com](http://www.aetnamedicaid.com)) or call us at the toll-free number on your/ your child’s ID card.

**What Health Education Classes Does Aetna Better Health Offer?**

We work with our community partners to make available free and/or low-cost classes for parents and children. Some health topics include:

Car Seat Safety	Poison Safety
Drug & Alcohol Awareness	Prenatal Care
Immunizations	Sexually Transmitted Diseases
Infant Mortality	Smoking Cessation
Nutrition	Teen Pregnancy Prevention
Oral Health	Vision Awareness
Physical Fitness	Weight Management

Please call us to learn more. Please check with your doctor before you begin any new health or wellness program.

**What Other Services or Programs are Available to Me or My Child?**

There are other services that are not a part of Aetna Better Health. You or your child can also be able to get some of these services or programs:

- Early Childhood Intervention (ECI) Program - ECI gives services to children ages 0 to 3 years whose development is delayed. Some of the services for children are: screenings, physical, occupational, speech and language therapy, and activities to help children learn better.
- Mental Illness or Mental Retardation (MHMR) Case Management - Coordination of care is given to help people get access to other needed services.
- Supplemental Nutrition Program for Women, Infants and Children (WIC)- WIC can help children under 5 years old and pregnant women to get nutritious food, nutrition education, and counseling.
- Texas Information and Referral Network (TIRN) – The phone number is 211. This is a **free** phone call which can help you find Health and Human Services in your local area.

# Health Care and Other Services

References to “you,” “my,” or “I” apply if you are a CHIP Member. References to “my child” or “my daughter” apply if your child is a CHIP Member.

## Routine Medical Care

### *What Is Routine Medical Care?*

### *How Soon Can I Expect My Child to be Seen?*

**Routine care** is the non-emergency or non-urgent care that you or your child receives from their Primary Care Provider or other healthcare provider.

The Primary Care Provider you picked for yourself or your child is called your “medical home” and will help you with all of your/ your child’s medical care. Your Primary Care Provider will provide you or your child with regular check-ups and treatment when needed. Your Primary Care Provider will order prescription drugs and medical supplies. Your Primary Care Provider will also send you or your child to a specialist if needed. A specialist can be your/ your child’s Primary Care Provider if decided by your/ your child’s Primary Care Provider and us. It is important that you follow your/ your child’s Primary Care Provider’s advice and take part in decisions about your/ your child’s healthcare.

When you or your child needs care, call his/her Primary Care Provider’s phone number on your/ your child’s ID card. The doctor’s office or clinic will make an appointment for you or your child. It is very important that you keep your / your child’s appointments. If you cannot keep an appointment, please call your/ your child’s doctor to let him/her know. Your/ your child’s Primary Care Provider should be able to see you or your child within two (2) weeks after you ask for a routine care appointment or within eight (8) weeks after you ask for an appointment for a physical or a wellness check up.

## Urgent Medical Care

### *What Is Urgent Medical Care?*

### *How Soon Can I Expect My Child to be Seen?*

**Urgent care** is when you or your child has a medical problem that is **not** an emergency, including a cold, cough, small cuts, minor burns or bruises.

You must first call your/ your child’s Primary Care Provider at the number shown on your/ your child’s ID card. If you would like to speak to a nurse you can call the Informed Health Line at 1-800-556-1555. The nurse can help decide if you or your child needs to go to the emergency room. Many illnesses do not need to be treated in the ER. A cold, cough, rash, small cuts, minor burns or bruises are not good reasons to go to the ER. If you or your child needs urgent care, the Primary Care Provider should see you or your child within 24 hours after you ask for care.

## Emergency Care

### *What Is Emergency Medical Care?*

### *How Soon Can I Expect My Child to be Seen?*

### *What is an Emergency, an Emergency Medical Condition and an Emergency Behavioral Health Condition?*

Emergency care is a covered CHIP service. Emergency care is provided for Emergency Medical Conditions and Emergency Behavioral Health Conditions. **“Emergency Medical Condition”** means a medical condition of recent onset and severity, including, but not limited to, severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the child’s condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

- placing the child’s health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- serious disfigurement; or

- in the case of a pregnant child, serious jeopardy to the health of the fetus.

“Emergency Behavioral Health Condition” means any condition, without regard to the nature or cause of the condition, that in the opinion of a prudent layperson, possessing average knowledge of medicine and health:

- requires immediate intervention and/or medical attention without which the child would present an immediate danger to himself or others; or
- that renders the child incapable of controlling, knowing or understanding the consequences of his actions.

### **What is Emergency Services and/or Emergency Care?**

**“Emergency Services” and/or “Emergency Care”** means health care services provided in an in-network or out-of-network hospital emergency department or other comparable facility by in-network or out-of-network physicians, providers, or facility staff to evaluate and stabilize Emergency Medical Conditions and/or Emergency Behavioral Health Conditions. Emergency services also include, but are not limited to, any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an Emergency Medical Condition and/or Emergency Behavioral Health Condition exists.

### **Guidelines**

You should be seen right away if you or your child needs emergency care. Whether you are in or out of one of our service areas, we ask that you follow the guidelines below when you believe you or your child needs emergency care.

- Call 911 or the local emergency hotline or go to the nearest emergency facility. If a delay would not be harmful to your/ your child’s health, call your/ your child’s Primary Care Provider. Tell your/ your child’s Primary Care Provider as soon as possible after getting treatment.
- As soon as your/ your child’s health condition is stabilized, the emergency facility should call your/ your child’s Primary Care Provider for information on your/ your child’s medical history.
- If you or your child is admitted to an inpatient facility, you, a relative or friend on your behalf should tell your/ your child’s Primary Care Provider as soon as possible.

Some good reasons to go to the ER are:

- danger of losing life or limb
- very bad chest pains
- poisoning or overdose of medicine
- choking or problems breathing
- possible broken bones
- uncontrolled diarrhea or vomiting
- heavy bleeding
- serious injuries or burns
- fainting
- suddenly not being able to move (paralysis)
- victim of violent attack (rape, mugging, stab, or gunshot wound)
- you or your child has thoughts of causing harm to self or others
- about to deliver a baby

### **What Is Post Stabilization?**

**“Post-stabilization care services”** are services covered by CHIP that keep your condition stable following emergency medical care.

### **Follow-Up Care after Emergency**

You or your child might need follow-up care after going to the emergency room. If so, make an appointment with your/ your child’s Primary Care Provider. Do not go back to the emergency room (unless it is an emergency). Do not go back to the doctor that treated you or your child at the hospital unless told to by your/ your child’s Primary Care Provider.

### **Emergency Dental Care**

## ***Are Emergency Dental Services Covered?***

Your child's CHIP medical plan will pay for some emergency dental services, such as:

- Dislocated jaw.
- Traumatic damage to teeth and supporting structures.
- Removal of cysts.
- Treatment of oral abscess of tooth or gum origin.
- Treatment and devices for craniofacial anomalies.
- Drugs for any of the above conditions.

The CHIP medical plan also covers dental services your child gets in the hospital. This includes services from the doctor providers and other services your child might need, like anesthesia.

## ***What Do I Do If My Child Needs Emergency Dental Care?***

During normal business hours, call your child's Main Dentist to find out how to get emergency services. If your child needs emergency dental services after the Main Dentist's office has closed, call us toll-free at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar).

## **After-Hours Care**

### ***Who Do I Call for Medical Care After My/ My Child's Primary Care Provider's Office is Closed?***

If you or your child's Primary Care Provider office is closed and you or your child gets sick at night or on a weekend and cannot wait to get medical care, call your/ your child's Primary Care Provider for advice. Your/ your child's Primary Care Provider or another doctor is ready to help by phone 24 hours a day, 7 days a week. You may also call the Informed Health Line at 1-800-556-1555 to help you decide what to do.

## **Getting Care When Traveling**

### ***What If I Am/ My Child Gets Sick When We Are Out of Town or Traveling? What if I Am My Child is Out of the State?***

If you/ your child needs medical care when traveling, call us toll-free at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar) and we will help you find a doctor. If you/ your child need emergency services while traveling go to a nearby hospital, then call us toll-free at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar)

### ***What If I Am/ My Child Gets Sick When We Are Out of the Country?***

Medical services performed out of the country are not covered by CHIP.

## **Explanation of Precertification, Referral & Medically Necessary**

### ***What is Precertification?***

Some services need approval before they are given. Your/ your child's doctor should get this approval from us before you or your child is treated. You can ask us or your/ your child's doctor if an approval is needed for a service or treatment.

### ***What is a Referral?***

A referral is an approval from your/ your child's Primary Care Provider for you or your child to get covered specialty care and follow-up treatment.

### ***Important Points About Referrals:***

- You should talk to your/ your child's Primary Care Provider about the referral to know what specialist services you or your child might be getting and why.

- Only some benefits can be accessed directly. If the specialist suggests more treatments or tests, you might need another referral from your/ your child's Primary Care Provider. If you or your child needs another referral and you do not get one, you might have to pay.
- You **cannot ask for referrals** for specialist services **after** you or your child goes to see a specialist. You must receive the referral from your/ your child's Primary Care Provider first before seeking specialty care (except in an emergency).

**What Services Do Not Need a Referral?**

The following services **do not** require a referral and can be accessed directly:

- Emergency care
- OB/GYN care
- Behavioral health (mental health and drug and alcohol abuse) services.

**What does Medically Necessary Mean?**

Covered services for CHIP Members and CHIP Perinate Newborn Members must meet the CHIP definition of "Medically Necessary."

**Medically necessary** means:

(1) Health Care Services that are:

- (a) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a Member, or endanger life;
- (b) provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member's health conditions;
- (c) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
- (d) consistent with the diagnoses of the conditions;
- (e) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
- (f) not experimental or investigative; and
- (g) not primarily for the convenience of the Member or Provider; and

(2) Behavioral Health Services that are:

- (a) reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
- (b) in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
- (c) not experimental or investigative; and
- (d) not primarily for the convenience of the Member or Provider.

**Medically Necessary Services** must be furnished in the most appropriate and least restrictive setting in which services can be safely provided and must be provided at the most appropriate level or supply of service that can safely be provided and that could not be omitted without adversely affecting the child's physical health and/or the quality of care provided.

**Specialty Care**

**What if I / My Child Needs to See the Special Doctor (Specialist)?**

Your/ your child's Primary Care Provider can send you to another doctor if you or your child needs a special type of care your Primary Care Provider cannot give. Your/ your child's Primary Care Provider will tell you if you or your child needs to see a specialist. You should not go to another doctor for services if your/ your child's Primary Care Provider does not agree to make a referral. If you or your child sees a specialist without a referral, you might have to pay for the services.

**How Soon Can I / My Child expect to Be Seen by the Specialist?**

After getting a referral from your/ your child's Primary Care Provider, you should be able to go or take your child to see a specialist within 3 weeks for a routine appointment; within 24 hours for urgent care appointments.

### ***How Can I Ask for a Second Opinion?***

You can get a second opinion about the use of any health care service from a network provider. If a network provider is not available, you can see an out-of-network provider. There is no cost to you for getting a second opinion. To learn more on how to ask for a second opinion please call us at the toll free number on your/ your child's ID card.

## **Behavioral Health**

### **How Do I Get Help If I or My Child Has Behavioral (Mental) Health or Drug Problems?**

Aetna Better Health will help you get the behavioral health care services you or your child needs (e.g., treatment or care for mental disease or illness, alcohol abuse and/or substance abuse).

Our goal is to give you more choices in the places you get care for yourself or your child. We will work with your doctor to help pick the best choice for you or your child. We will cover partial hospitalization and extended day treatment programs when medically appropriate. These extra benefits will help you and your child get the care he or she needs in the least restrictive setting.

If you or your child is having a mental health, alcohol or drug abuse problem, you can call your/ your child's Primary Care Provider for an appointment or call us toll-free at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar).

For behavioral health care services, call us at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar). Your/ your child's behavioral health doctor should be able to see you or your child within two (2) weeks after you ask for routine appointment. If you or your child has a behavioral health emergency and needs treatment, go to the nearest Emergency Room. You or someone on your child's behalf will need to call us at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar) and tell us you or your child had an emergency.

### ***Do I Need a Referral for This?***

You do not need a referral from your/your child's Primary Care Provider to get behavioral health care services for you or your child.

## **Women's Health**

### **Obstetric and Gynecologic Care**

#### **ATTENTION MEMBERS**

### ***What If I Need or My Daughter Needs Ob/Gyn Care? Do I Have the Right to Choose an Ob/Gyn?***

You have the right to select an Ob/Gyn for yourself/ your daughter without a referral from your/ your daughter's Primary Care Provider. An Ob/Gyn can give you:

- one well-woman checkup each year
- care related to pregnancy
- care for any female medical condition;
- referral to special doctor (specialist) within the network

Aetna Better Health allows you/ your daughter to pick an Ob/Gyn for you/ your daughter but this doctor must be in the same network as your/ your daughter's Primary Care Provider.

### ***How Do I Choose an Ob/Gyn?***

Check our Provider Directory to find an Ob/Gyn for you or your child. You can get a copy of the provider directory online at [www.aetnamedicaid.com](http://www.aetnamedicaid.com) or call us at the toll-free number on your/ your child's ID card for help in finding an Ob/Gyn.

### ***If I Don't Choose an Ob/Gyn, Do I Have Direct Access?***

You have the right to pick an Ob/Gyn from our network for yourself/ your child without a referral from your Primary Care Provider.

### ***Will I Need a Referral?***

You have the right to pick an Ob/Gyn from our network for yourself/ your child without a referral from your Primary Care Provider.

### ***How Soon Can I / My Daughter Be Seen After Contacting my Ob/Gyn for an Appointment?***

If you or your child is pregnant, you /she should be seen within 2 weeks of enrollment or by the 12th week of your/her pregnancy. If you or your child is not pregnant, she should be seen within 3 weeks of asking for an appointment.

### ***Can I / My Daughter stay with an Ob/Gyn Who is not With Aetna Better Health?***

If you or your daughter is past the 24<sup>th</sup> week of pregnancy when you/ she joins she will be able to stay under the care of your/ her current Ob/Gyn. If you/she chooses, you/she can pick an Ob/Gyn who is in our network as long as the doctor agrees to treat you/her. We are available to help with the changes between doctors.

### ***What If My I am Pregnant or my Daughter is Pregnant? Who do I Need To Call?***

Call us at the toll-free number on your/ your child's ID card as soon as you know you or your daughter is pregnant. You/ she needs to apply right away for Medicaid services. Your/ your daughter's baby will be enrolled in Medicaid from birth up to a year old if you/ she enrolls in Medicaid while you/ she is pregnant.

**If you or your daughter does not enroll in Medicaid while you/ she is pregnant, you/ she will have to apply for coverage for your/her newborn after the baby is born. Please note that there could be a gap in coverage for your/her baby.**

## **What Other Services/Activities/Education Does Aetna Better Health Offer Pregnant Women?**

### ***Case Management***

Case management is given to members who are pregnant. Our Case managers help members to get the services that they might need. We can also help you get referrals when needed.

### ***Prenatal Education***

We will mail a prenatal packet to all pregnant women. The packet has information about how to stay healthy during pregnancy and a list of child birth classes and much more.

## **Other Member Services**

### **Special Health Care Needs**

#### ***Who Do I Call if I Have/ My Child Has Special Health Care Needs and I Need Someone to Help Me?***

Our Case Managers are ready to help coordinate services for children with special health care needs. You or your child can also have his/her health care given by a specialist if you or your child has special health care needs. If you or your child has special health care needs and you need someone to help you, please call us at the toll-free number on your/ your child's ID card to learn more.

### **Member Services Notification**

#### ***What Do I Have to Do If I Move/ My Child Moves?***

As soon as you have your new address, give it to the local HHSC benefits office and Aetna Better Health Member Services Department at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar). Before you get CHIP services in your new area, you must call Aetna Better Health, unless you need emergency services. You will continue to get care through Aetna Better Health until HHSC changes your address.

## Interpreter Services

### ***Can Someone Interpret for Me When I Talk with My/ My Child's Doctor? Who Do I Call for an Interpreter?***

Our Member Services staff speaks both English and Spanish. We have a language line if you do not speak English or Spanish. If you need an interpreter, call us at the toll-free number on your/ your child's ID card. At the time of your call, we will get a language interpreter that speaks your language on the line. People that are deaf or hearing impaired can call the TTY line toll-free at 1-800-735-2989.

### ***How Can I Get a Face-to-Face Interpreter in the Provider's Office? How Far in Advance Do I Need to Call?***

We can help you if you need an interpreter to go with you to your/ your child's doctor's office. As soon as you know the date of your/ your child's appointment, please call us at the toll-free number on your/ your child's ID card. We ask for 72 hours advance notice of a need for an interpreter.

## Member Rights and Responsibilities

### **Members Have the Right To:**

1. You have the right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals and other providers.
2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. "Limited provider network" means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same "limited network."
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides whether a service is covered and/or medically necessary. You have the right to know about the people in the health plan who decide those things.
5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.
8. Children who are diagnosed with special health care needs or a disability have the right to special care.
9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months and the health plan must continue paying for those services. Ask your plan about how this works.
10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first

checking with your health plan. You may have to pay a co-payment depending on your income. Copayments do not apply to CHIP Perinatal members

12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right to speak for your child in all treatment choices.
14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
15. You have the right to be treated fairly by your health plan, doctors, hospitals and other providers.
16. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.
17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
18. You have the right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

### **Member Responsibilities:**

You and your health plan both have an interest in seeing your child's health improve. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
2. You must become involved in the doctor's decisions about your child's treatments.
3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
5. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. If your child has CHIP, you are responsible for paying your doctor and other providers co-payments that you owe them. If your child is getting CHIP Perinatal services, you will not have any co-payments for that child.
8. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other members, or health plans.
9. You must talk to your provider about your medications that are prescribed.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services toll-free at 1-800-368-1019. You also can view information concerning the HHS Office of Civil Rights online at [www.hhs.gov/ocr](http://www.hhs.gov/ocr).

## Plan Coverage

### How Does Renewal Work?

#### Requalifying for CHIP

It's important to renew your/ your child's CHIP/Children's Medicaid coverage every twelve (12) months to prevent a lapse in coverage.

In your tenth month of coverage HHSC will mail a renewal packet to you that contains an application with some of your information already filled in.

- Update information as needed.
- Fill in all the questions that have been left blank
- Make sure to send in copies of at least one paycheck stub or other document showing each family member's income and expenses.
- Sign and date the application then send it in using the postage-paid return address envelope.

Missing information or documents can cause a delay in working on your application. Call 1-877-KIDS-NOW (1-877-543-7669) to get help renewing your coverage.

## Member Safety

We are committed to educating our members about health safety. Research shows that most medical errors can be prevented by being an active participant in your/ your child's health care. Here are some important tips:

- *Be involved in every decision about your/ your child's health care.* You are more likely to know what you and your provider can do to improve and/or maintain your/ your child's health if you are involved with your/ your child's health care.
- *Ask questions.* You have a right to question anyone who is involved with your/ your child's care.
- *Make sure your child's provider knows about all medications you or your child is taking,* including prescriptions, over-the-counter medications and dietary supplements such as vitamins and herbs. Ask that these be written down in your/ your child's file.
- *Make sure your/ your child's doctor knows if you or your child has any allergies or bad reactions to medications.* This can help you avoid getting medications that could harm you or your child.
- *Ask for information about your/ your child's medical treatment in a language you can understand.* Be sure you know all the basics, such as medication dosage, drug interactions, possible side effects and why a particular medication and/or treatment is being recommended.

## Complaint Process

### Complaints

#### **What Should I Do if I Have a Complaint? Who Do I Call?**

We want to help. If you have a complaint, please call us toll-free at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar) to tell us about your problem. An Aetna Better Health Member Services Advocate can help you file a complaint. Just call 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar). Most of the time, we can help you right away or at the most within a few days.

### ***Can Someone from Aetna Better Health Help Me File a Complaint?***

The Member Advocate can help you file a complaint. The Member Advocate will write down your concern. You can also send a written complaint to the Member Advocate at:

Aetna Better Health  
Attention: Member Advocate  
PO Box 569150  
Dallas, TX 75356-9150  
1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar) or 214-200-8140

### ***How Long Will It Take to Process My Complaint? What are the Requirements and Timeframes for Filing a Complaint?***

When we get the complaint from you, we will send you a letter within five (5) days to let you know that we got it. We will send you another letter within thirty (30) days from the date we got your complaint that will give you the results.

### ***If I am Not Satisfied with the Outcome, Who Else Can I Contact?***

If you are not happy with the result of your complaint, you can call us at the toll-free number on your/ your child's ID card and ask for an appeal. You can also ask for an appeal of a complaint resolution by writing to:

Aetna Better Health  
Attention: Member Advocate  
PO Box 569150  
Dallas, TX 75356-9150  
1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar) or 214-200-8140

### ***Do I Have the Right to Meet with a Complaint Appeal Panel?***

Within five (5) days of getting your request for an Appeal, the Member Advocate will send you a letter to let you know that your appeal came to us. The Appeal Panel will look over the information you submitted and discuss your/ your child's case. It is not a court of law. You have the right to appear in front of the Appeal Panel at a specified place to talk about the written appeal you sent us. When we make the decision on your appeal, we will send you a response in writing within thirty (30) days after we get the appeal.

You also have the right to file a complaint with the Texas Department of Insurance (TDI) by calling toll free at 1-800-252-3439, or in writing at:

Texas Department of Insurance  
Consumer Protection  
PO Box 149091  
Austin, TX 78714-9091  
  
Fax: (512) 475-1771  
Web: <http://www.tdi.state.tx.us>  
Email: [ConsumerProtection@tdi.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)

## **Appeal Process**

### **Appeal**

#### ***What Can I Do if My Doctor Asks for a Service or Medicine for Me/ My Child That's Covered but Aetna Better Health Denies or Limits It ?***

If we deny or limit your doctor's request for a covered service for your/ your child, you have the right to ask for an appeal. You or your child's doctor can send us more information to show why you do not agree with the decision. You can call us and ask for an appeal. The Member Advocate will write down the information and send it to you to look over. A written appeal can be sent to:

Aetna Better Health  
Attention: Member Advocate  
PO Box 569150  
Dallas, TX 75356-9150

***How Will I Find Out If Services are Denied?***

If your child's services are denied, you and your child's doctor will get a letter that tells you the reason for denial. The letter will also tell you how to file an appeal and how to ask for a review by an Independent Review Organization (IRO).

***What are the Timeframes for the Appeal Process?***

You can appeal a decision to deny services at any time after you are told of the decision. The timeframe for the resolution of the appeal will depend on what services have been denied. If you or your child is in the hospital or is already getting services that are being limited or denied, you can call and ask for an expedited appeal. The expedited appeal process is explained below.

For a standard appeal, the Member Advocate will send you a letter within five (5) days of getting your request for an Appeal to let you know that we got it. We will send all available information to a doctor who was not involved in making the first decision. You will get a written response on your appeal within thirty (30) days after we get the appeal.

***When Do I Have the Right to Ask for an Appeal?***

If you don't agree with the decision made by us, you can ask us for an appeal. You do not have a right to an appeal if the services you asked for are not covered under the CHIP program or if a change is made to the state or federal law, which affects CHIP members.

***Does My Request Have to be in Writing?***

Your request does not have to be in writing. You can ask for an appeal by calling us at the toll-free number listed on your/ your child's ID card and ask for the Member Advocate. We will write down what you tell us and send it to you to review

***Can Someone from Aetna Better Health Help Me File an Appeal?***

You can get help in filing an appeal by calling us at the toll-free number listed on your/ your child's ID card or writing to:

Aetna Better Health  
Attention: Member Advocate  
PO Box 569150  
Dallas, TX 75356-9150

The Member Advocate will listen to your appeal and tell you about the rules. The Member Advocate will answer your questions and see that you are treated fairly.

## **Expedited Appeal Process**

### **Expedited Appeal**

***What is an Expedited Appeal?***

An Expedited Appeal is when the health plan has to make a decision quickly based on the condition of your health, and taking time for a standard appeal could jeopardize your life or health.

***How do I Ask for an Expedited Appeal?***

You can ask for an expedited appeal by calling us toll-free 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar). A written expedited appeal can be sent to:

Aetna Better Health  
Attention: Member Advocate  
PO Box 569150  
Dallas, TX 75356-9150

### ***Does My Request Have to be in Writing?***

Your request does not have to be in writing. You can ask for an expedited appeal by calling us at the toll-free number listed on your/ your child's ID card

### ***What are the Timeframes for an Expedited Appeal?***

The timeframe for resolution of your request of an expedited appeal will be based on your medical emergency condition, procedure, or treatment, but will not take more than one (1) business day from the date we get all information needed to review your appeal.

### ***What Happens if Aetna Better Health Denies the Request for an Expedited Appeal?***

If you ask for an expedited appeal that does not involve an emergency, a hospital stay or services that are already being given, you will be told that the appeal review cannot be rushed. We will keep working the appeal and respond to you within thirty (30) days from the time we got your appeal.

If you do not agree with this decision, you can ask for an outside review by an Independent Review Organization (IRO). The procedure to ask for a review by an IRO is explained below. You can also file a complaint with the Texas Department of Insurance by calling toll free at 1-800-252-3439 or writing to:

Texas Department of Insurance  
Consumer Protection  
PO Box 149091  
Austin, TX 78714-9091

Fax: (512) 475-1771

Web: <http://www.tdi.state.tx.us>

Email: [ConsumerProtection@tdi.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)

### ***Who Can Help Me in Filing an Appeal?***

You can ask for an appeal by calling us at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar) and asking for the Member Advocate or writing to:

Aetna Better Health  
Attention: Member Advocate  
PO Box 569150  
Dallas, TX 75356-9150

The Member Advocate will listen to your appeal and tell you about the rules. The Member Advocate will answer your questions and see that you are treated fairly.

## **Independent Review Organization (IRO)**

### ***What is an Independent Review Organization (IRO)?***

An IRO is an organization that has no connection to us or the doctors that were previously involved in your treatment or decisions made by us about services that have not been given.

### ***How Do I Ask for a Review by an Independent Review Organization?***

You can ask for an IRO review by filling out the "Request For A Review By An Independent Review Organization" form that is sent with the decision letter. You will have 15 days from the day you get our decision letter to send it back to us. Once we get the completed form, we will tell the Texas Department of Insurance (TDI) of your request for an IRO review. There is no cost to you for an independent review.

If you need help filling out the IRO form, please call the toll-free number on your/ your child's ID card. We will be happy to help you.

### ***What are the Timeframes for this Process?***

The standard timeframe for the IRO process should take no longer than twenty (20) calendar days from the date the IRO gets all of your information.

If you have an emergency health condition, the IRO process should take no longer than eight (8) calendar days from the date the IRO gets all of your information.

## **Fraud Information**

### **Do you want to report CHIP Waste, Abuse, or Fraud?**

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting CHIP benefits is doing something wrong. Doing something wrong could be waste, abuse or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their CHIP ID.
- Using someone else's CHIP ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

### **To report waste, abuse, or fraud, choose one of the following:**

- Call the OIG Hotline at 1-800-436-6184;
- Visit <https://oig.hhsc.state.tx.us/> and pick "Click Here to Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to your health plan:  
Aetna Better Health  
Attention: SIU Coordinator  
PO Box 569150  
Dallas, TX 75356-9150  
1-888-761-5440

### **To report waste, abuse or fraud, gather as much information as possible.**

When reporting about a provider (a doctor, dentist, counselor, etc.) include:

- Name, address, and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc)
- Medicaid number of the provider and facility , if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened.

When reporting about someone who gets benefits include:

- The person's name
- The person's date of birth, Social Security Number, or case number if you have it
- The city where the person lives
- Specific details about the waste, abuse or fraud.

# Subrogation

## Subrogation

### ***What is subrogation?***

We might ask for payment for medical expenses to treat an injury or illness that was caused by someone else. This is a “right of subrogation” provision. Under our right of subrogation, we reserve the right to get back the cost of medical benefits paid when another party is (or might be responsible) for causing the illness or injury to you. We can ask to get back the cost of medical expenses from you if you get expenses from the other party.

# Your CHIP Perinate Member Handbook

This handbook is a guide to help you know your Aetna Better Health benefits.

If you have questions about your benefits or what is covered, please go to the benefits section.

If you cannot find the answer to your question(s) in this handbook, use our website [www.aetnamedicaid.com](http://www.aetnamedicaid.com), or call us at the toll-free number on your ID card. We will be happy to help you. To learn more about us, turn to page iii.

## Tips for members

5. Keep this handbook and any additional handbook information for future use.
6. Write your ID number(s) in the front of this book or other safe place.
7. Always carry your ID card with you.
8. Keep your Perinatal Provider's name and number near the phone.
9. Use the Hospital Emergency Room (ER) only for emergencies.

# How Your Plan Works

## The Basics

- You pick a primary care provider from our large list of doctors.
- You go to your Primary Care Provider for routine and preventive care or when other care is needed, such as for an illness or injury.
- Your Primary Care Provider will send you to a specialist or coordinate care when needed.
- You pay copayments for certain medical services at the time of your doctor visit.
- You have coverage in an emergency.

## Health Plan ID Card

When you are enrolled with us, you will get an ID card from us. The front of the Aetna Better Health CHIP Perinate ID card shows important information about you, as well as the name and the phone number of the health plan. The back of the card also has important phone numbers for you to call if you need help. Please make sure your information on the ID card is correct.

Always carry your Aetna Better Health CHIP Perinate ID card with you when going to see the doctor. You will need it to get health care. You must show it each time you get services.

You will not get a new ID card every month. If your card is lost or stolen, please call us right away so we can send you another ID card. If your address or phone number changes, please call our Member Services Department so we can send you a new card with the correct information.

## Example of an Aetna Better Health CHIP Perinate ID card (<185% FPL)

	Children's Health Insurance Program	TDI
	<b>Attention Provider You Must Call 1-800-245-5380 For Pre-certification Or Case Management</b>	

MEMBER NAME:  
MEMBER ID:  
EFF. DATE:

Member Services / Servicios para Miembros: **1-800-245-5380**  
24 hours / 7 days per week /  
24 horas del día/siete días de la semana

Informed Health Line/ Línea de salud informada: **1-800-556-1555**

Relay Texas TTY: **1-800-735-2989**

MEMBER NOMBRE:  
MEMBER ID:  
EFFECTIVO:

**Pharmacy Coverage**  
RxBIN 610591  
RxPCN ADV  
RxGRP Rx8801  
**Pharmacist Use Only  
1.877.874.3317**

*Los servicios de la asistencia médica son limitados al cuidado del niño no nacido aún.*

**Co-pays do not apply.**

*Health Care Services are limited to the care of the unborn child.*

**Co-pagos no se aplica.**

### Directions for What to Do In An Emergency

In case of emergency call 911 or go to the closest emergency room.

For additional information regarding emergency services, please refer to your Aetna Better Health member handbook.

*In case of an emergency, please call 911*

### Instrucciones en caso de emergencia.

En caso de emergencia, llama al 911 o vaya a la sala de emergencia más cercana.

Para más información sobre servicios de emergencia, avor de referirse al Manual para Miembros del Aetna Better Health .

*En caso de una emergencia, por favor llama al 911*

### Professional/Other Services Billing

Claims Processing Center  
P.O. Box 60938  
Phoenix, AZ 85082  
Payor ID: 38692

### Hospital Facility Billing

TMHP-Attn: Claim Administrator  
12365-A Riata Trace Pkwy  
Austin, TX 78727

### El profesional/otro mandar la

cuenta de los servicios Claims  
Processing Center  
P.O. Box 60938  
Phoenix, AZ 85082  
Payor ID: 38692

### Facturación de la facilidad del

hospital  
TMHP-Attn: Claim Administrator  
12365-A Riata Trace Pkwy  
Austin, TX 78727

## Example of an Aetna Better Health CHIP Perinate ID card (186% - 200% FPL)

	Children's Health Insurance Program	TDI
	<b>Attention Provider You Must Call 1-800-245-5380 For Pre-certification Or Case Management</b>	

MEMBER NAME:  
MEMBER ID:  
EFF. DATE:  
:

Member Services / Servicios para Miembros: **1-800-245-5380**  
24 hours / 7 days per week /  
24 horas del día/siete días de la semana

Informed Health Line/ Línea de salud informada: **1-800-556-1555**

Relay Texas TTY: **1-800-735-2989**

MEMBER NOMBRE:  
MEMBER ID:

**Pharmacy Coverage**  
RxBIN 610591  
RxPCN ADV  
RxGRP Rx8801  
**Pharmacist Use Only  
1.877.874.3317**

*Los servicios de la asistencia médica son limitados al cuidado del niño no nacido aún.*

**Co-pays do not apply.**

*Health Care Services are limited to the care of the unborn child.*

**Co-pagos no se aplica.**

### Directions for What to Do In An Emergency

In case of emergency call 911 or go to the closest emergency room.

For additional information regarding emergency services, please refer to your member handbook.

*In case of an emergency, please call 911*

### Instrucciones en caso de emergencia.

En caso de emergencia, llama al 911 o vaya a la sala de emergencia más cercana. .

Para más información sobre servicios de emergencia, avor de referirse al Manual para Miembros.

*En caso de una emergencia, por favor llama al 911*

### Professional/Other Services Billing

Claims Processing Center  
P.O. Box 60938  
Phoenix, AZ 85082  
Payor ID: 38692

### Envíe reclamaciones a este dirección.

Claims Processing Center  
P.O. Box 60938  
Phoenix, AZ 85082  
Payor ID: 38692

## Perinatal Provider Information

### Visiting Your Perinatal Provider

#### ***What Do I Need To Bring with Me to a Perinatal Provider's Appointment?***

You should take the following items with you when you go to your doctor's appointment:

- Aetna Better Health ID card
- A list of all over-the-counter and prescription medications that you take
- Paper to take notes on information you get from the doctor.

### Choosing Your Perinatal Provider

#### ***Can a Clinic Be a Perinatal Provider?***

If you have been getting health care services at a clinic and you want to keep going there, please pick one of the doctors in the clinic as your Perinatal Provider. The Perinatal Provider you pick needs to be listed in our Provider Directory.

Some of the providers that you can also pick from to be your Perinatal Provider are: Ob/Gyns (woman's doctor); Local Public Health Clinics; Federally Qualified Health Clinics (FQHCs); and Rural Health Clinics (RHCs).

#### ***How Do I Choose a Perinatal Provider?***

Please look at our Provider Directory to get more information on Perinatal Providers. You must pick a Perinatal Provider who is in our Aetna Better Health CHIP Perinate network. You can get a copy of the provider directory on [www.aetnamedicaid.com](http://www.aetnamedicaid.com) or by calling us at the toll-free number listed on your ID card.

#### ***How Soon Can I Be Seen After Contacting a Perinatal Provider for an Appointment?***

You should be seen by a Perinatal Provider within 2 weeks of asking for an appointment. If you have problems getting an appointment, please call us at 1-800359-5613.

#### ***Can I Stay with a Perinatal Provider if They Are Not with Aetna Better Health CHIP Perinate?***

If you are past the 24<sup>th</sup> week of pregnancy when you join you will be able to stay under the care of your current Perinatal Provider. If you choose, you can pick a Perinatal Provider who is in our network as long as the doctor agrees to treat you. We are available to help you with the changes between doctors.

### After Hours Care

#### ***How Do I Get After Hours Care?***

If you get sick at night or on a weekend and cannot wait to get medical care, call your Perinatal Provider. Your Perinatal Provider or another doctor is ready to help by phone 24 hours a day, 7 days a week. You may also call the 24-hour Informed Health Line<sup>®</sup> at 1-800-556-1555 to speak with a registered nurse to help you decide what to do. Remember to keep your CHIP Perinate ID card with you at all times.

## Health Plan Information

### Changing Your Health Plan

- **ATTENTION:** If you meet certain income requirements, your baby will be moved to Medicaid and get 12 months of continuous Medicaid coverage from date of birth.
- Your baby will continue to receive services through the CHIP Program if you meet the CHIP Perinatal requirements. Your baby will get 12 months of continuous CHIP Perinatal coverage through his or her health plan, beginning with the month of enrollment as an unborn child.

### ***What If I Want to Change Health Plans? Who Do I Call?***

Once you pick a health plan for your unborn child, the child must stay in this health plan until the child's CHIP Perinatal coverage ends. The 12 month CHIP Perinatal coverage begins with your unborn child is enrolled in the CHIP Perinatal and continues after your child is born.

- If you live in an area with more than one CHIP health plan, and you do **not** pick a plan within 15 days of getting the enrollment packet, HHSC will pick a health plan for your unborn child and send you information about that health plan. If HHSC picks a health plan for your unborn child, you will have 90 days to pick another health plan if you are not happy with the plan HHSC chooses.
- If you have children covered by CHIP, their health plans might change once you are approved for CHIP Perinatal coverage. When a member of the family is approved for CHIP Perinatal coverage and picks a perinatal health plan, all children in the family that are enrolled in CHIP must join the health plan providing the CHIP Perinatal services. The children must remain with the same health plan until the end of the CHIP Perinatal Member's enrollment period, or the end of the other children's enrollment period, whichever happens last. At that point, you can pick a different health plan for the children. Copayments, cost-sharing, and enrollment fees still apply for those children enrolled in the CHIP Program.
- You can ask to change health plans:
  - for any reason within 90 days of enrollment in the CHIP Perinatal; and
  - for cause at any time.

For more information, call toll-free at 1-800-647-6558.

### ***How Many Times Can I Change Health Plans?***

There is no limit on how many times you can change health plans.

### ***When will my Health Plan Change Become Effective?***

If you call to change your health plan on or before the 15<sup>th</sup> of the month, the change will take place on the first day of the next month. If you call after the 15<sup>th</sup> of the month, the change will take place the first day of the second month after that. For example:

- If you call on or before April 15, your change will take place on May 1.
- If you call after April 15, your change will take place on June 1.

### ***Can Aetna Better Health Ask That I Get Dropped from Their Health Plan for Non-Compliance, etc?***

You can be disenrolled from our plan if:

- You permanently move out of the service area.
- You keep going to the ER when you do not have an emergency.
- You keep going to another doctor or clinic without first getting approval from your Perinatal Provider.
- You or your children show a pattern of disruptive or abusive behavior not related to a medical condition.
- You miss many visits without letting your doctor know in advance.
- You let someone else use your ID card.
- You often do not follow your doctor's advice.

# Benefits

## What are My Unborn Child's Perinatal Benefits?

Aetna Better Health provides CHIP Perinatal services as outlined below. There is no lifetime maximum on benefits; however, 12-month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart. Co-pays do not apply to CHIP Perinatal Members.

Type of Benefit	Description of Benefit	Limitations	Co-Pay
<b>Inpatient General Acute</b>	<p>Services include: Covered medically necessary Hospital-provided services</p> <ul style="list-style-type: none"> <li>• Operating, recovery and other treatment rooms</li> <li>▪ Anesthesia and administration (facility technical component)</li> <li>▪ Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero).</li> <li>▪ Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: <ul style="list-style-type: none"> <li>▪ dilation and curettage (D&amp;C) procedures,</li> <li>▪ appropriate provider-administered medications,</li> <li>▪ ultrasounds, and histological examination of tissue samples.</li> </ul> </li> </ul>	<p>For CHIP Perinates in families with incomes at or below 185% of the Federal Poverty Level, the facility charges are not a covered benefit; however professional service charges associated with labor with delivery are a covered benefit.</p> <p>For CHIP Perinates in families with incomes above 185% up to and including 200% of the Federal Poverty Level, benefits are limited to professional service charges and facility charges associated with labor with delivery until birth.</p>	<b>Co-pays do not apply</b>
<b>Comprehensive Outpatient Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center</b>	<p>Services include the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:</p> <ul style="list-style-type: none"> <li>• X-ray, imaging, and</li> </ul>	<p>May require prior authorization and physician prescription</p> <p>Laboratory and radiological services are limited to services that directly relate to ante partum care and/or the</p>	<b>Co-pays do not apply</b>

Type of Benefit	Description of Benefit	Limitations	Co-Pay
	<p>radiological tests (technical component)</p> <ul style="list-style-type: none"> <li>• Laboratory and pathology services (technical component)</li> <li>• Machine diagnostic tests</li> <li>• Drugs, medications and biologicals that are medically necessary prescription and injection drugs</li> <li>• Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: <ul style="list-style-type: none"> <li>• dilation and curettage (D&amp;C) procedures,</li> <li>• appropriate provider-administered medications,</li> <li>• ultrasounds, and</li> <li>• histological examination of tissue samples.</li> </ul> </li> </ul>	<p>delivery of the covered CHIP Perinate until birth.</p> <p>Ultrasound of the pregnant uterus is a covered benefit of CHIP Perinatal when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age conformation, or miscarriage or non-viable pregnancy.</p> <p>Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits of CHIP Perinatal with an appropriate diagnosis.</p> <p>Laboratory tests for CHIP Perinatal are limited to: nonstress testing, contraction stress testing, hemoglobin or hematocrit repeated one a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client.</p> <p>Surgical services associated with (a) miscarriage or (b) a non-viable</p>	

Type of Benefit	Description of Benefit	Limitations	Co-Pay
		pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero) are a covered benefit.	
<b>Physician/Physician Extender Professional Services</b>	<p>Services include, but are not limited to the following:</p> <ul style="list-style-type: none"> <li>▪ Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth.</li> <li>▪ Physician office visits, in-patient and out-patient services</li> <li>▪ Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation</li> <li>▪ Medically necessary medications, biological and materials administered in Physician's office</li> <li>▪ Professional component (in/outpatient) of surgical services, including: <ul style="list-style-type: none"> <li>- Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth.</li> <li>- Administration of anesthesia by Physician (other than surgeon) or CRNA</li> <li>- Invasive diagnostic procedures directly related to the labor with delivery of the unborn child.</li> <li>- Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero).</li> </ul> </li> <li>▪ Hospital-based Physician</li> </ul>	<p>Does not require authorization for specialty services</p> <p>Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age conformation.</p> <p>Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentesis, and FIUT.</p>	<b>Co-pays do not apply</b>

Type of Benefit	Description of Benefit	Limitations	Co-Pay
	<p>services (including Physician-performed technical and interpretive components)</p> <ul style="list-style-type: none"> <li>▪ Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.)</li> </ul> <p>Professional services associated with miscarriage or non-viable pregnancy include, but are not limited to: dilation and curettage (D&amp;C) procedures, appropriate provider-administered medications, ultrasounds, and histological examination of tissue samples.</p>		
<p><b>Birthing Centers</b></p>	<p>Covers birthing services provided by a licensed birthing center.</p>	<p>Limited to facility services (e.g., labor and delivery).</p> <p>Applies only to CHIP Perinate Members (unborn child) with incomes at 186% FPL to 200% FPL.</p>	<p><b>Co-pays do not apply</b></p>
<p><b>Services rendered by a Certified Midwife or physician in a licensed birthing center</b></p>	<p>Covers prenatal birthing, and postpartum services rendered in a licensed birthing center. Prenatal services subject to the following limitations:</p> <p>Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include:</p> <ol style="list-style-type: none"> <li>(1) One (1) visit every four (4) weeks for the first 28 weeks of pregnancy;</li> <li>(2) One (1) visit every two (2) to three (3) weeks from 28 to 36 weeks of pregnancy; and</li> <li>(3) One (1) visit per week from 36 weeks to delivery.</li> </ol> <p>More frequent visits are allowed as Medically Necessary.</p>	<p>Limit of 20 prenatal visits and two (2) postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained and is subject to retrospective review.</p> <p>Visits after the initial visit must include:</p> <ul style="list-style-type: none"> <li>• Interim history (problems, marital status, fetal status);</li> <li>• Physical examination (weight, blood pressure, fundalheight, fetal position and size, fetal heart rate, extremities) and</li> <li>• Laboratory tests (urinalysis for protein and glucose every visit;</li> </ul>	<p><b>Co-pays do not apply</b></p>

Type of Benefit	Description of Benefit	Limitations	Co-Pay
		<p>hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).</p>	
<p><b>Prenatal Care and Prepregnancy Family Services and Supplies</b></p>	<p>Covered services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include:</p> <p>One visit every four weeks for the first 28 weeks of pregnancy; one visit every two to three weeks from 28 to 36 weeks of pregnancy; and one visit per week from 36 weeks to delivery. More frequent visits are allowed as medically necessary.</p>	<p>Does not require prior authorization.</p> <p>Limit of 20 prenatal visits and 2 postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review.</p> <p>Visits after the initial visit must include: interim history (problems, maternal status, fetal status), physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) and laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of</p>	<p><b>Co-pays do not apply</b></p>

Type of Benefit	Description of Benefit	Limitations	Co-Pay
		client).	
<b>Emergency Services, including Emergency Hospital, Physicians, and Ambulance Services</b>	<p>Health Plan cannot require authorization as a condition for payment for emergency conditions related to labor and delivery.</p> <p>Covered services are limited to those emergency services that are directly related to the delivery of the covered unborn child until birth.</p> <ul style="list-style-type: none"> <li>• Emergency services based on prudent lay person definition of emergency health condition</li> <li>• Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child.</li> <li>• Stabilization services related to the labor and delivery of the covered unborn child.</li> <li>• Emergency ground, air and water transportation for labor and threatened labor is a covered benefit.</li> <li>• Emergency services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.)</li> </ul>	<p>Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.</p>	<p><b>Co-pays do not apply</b></p>
<b>Case Management Services</b>	<p>Case management services are a covered benefit for the unborn child.</p>	<p>These covered services include outreach informing, case management, care coordination and community referral.</p>	<p><b>Co-pays do not apply</b></p>
<b>Care Coordination Services</b>	<p>Care coordination services are a covered benefit for the unborn child.</p>		<p><b>Co-pays do not apply</b></p>
<b>Drug Benefits</b>	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>• Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and</li> <li>• Drugs and biological</li> </ul>	<p>Services must be medically necessary for the unborn child.</p>	<p><b>Co-pays do not apply</b></p>

Type of Benefit	Description of Benefit	Limitations	Co-Pay
	provided in an inpatient setting.		

### How do I get these services?

You should see your Perinatal Provider to ask about medical services. To learn more about how to obtain these or other services, please use the website ([www.aetnamedicaid.com](http://www.aetnamedicaid.com)) or call us at the toll-free number on your ID card.

### What Services are Not Covered?

- For CHIP Perinates in families with incomes at or below 185% of the Federal Poverty Level, inpatient facility charges are not a covered benefit if associated with the initial Perinatal Newborn admission. "Initial Perinatal Newborn admission" means the hospitalization associated with the birth.
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, and postpartum care related to the covered unborn child until birth. Services related to preterm, false or other labor not resulting in delivery are excluded services.
- Inpatient mental health services.
- Outpatient mental health services.
- Durable medical equipment or other medically related remedial devices.
- Disposable medical supplies.
- Home and community-based health care services.
- Nursing care services.
- Dental services.
- Inpatient substance abuse treatment services and residential substance abuse treatment services.
- Outpatient substance abuse treatment services.
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
- Hospice care.
- Skilled nursing facility and rehabilitation hospital services.
- Emergency services other than those directly related to the delivery of the covered unborn child.
- Transplant services.
- Tobacco Cessation Programs.
- Chiropractic Services.
- Medical transportation not directly related to the labor or threatened labor and/or delivery of the covered unborn child.
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment related to labor and delivery or post partum care.
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community. This exclusion is an adverse determination and is eligible for review by an Independent Review Organization.
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor and delivery
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care related to the labor and delivery of the covered unborn child.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity
- Medications prescribed for weight loss or gain
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care

- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Corrective orthopedic shoes
- Convenience items
- Over-the-counter medications
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.)
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training, vision therapy, or vision services
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered
- Donor non-medical expenses
- Charges incurred as a donor of an organ
- Coverage while traveling outside the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).

## **Your Out-of-Pocket Costs**

### ***How Much Do I Have to Pay for My Unborn Child's Health Care under CHIP Perinatal?***

No co-payments or cost sharing is required for covered services listed in the benefits section of this handbook. If you have any questions, please call the Member Services toll free phone number on your ID Card.

### ***Will I Have to Pay for Services that are Not a Covered Benefit?***

If the service is not a covered benefit listed in the benefits section of this handbook, then you will have to pay for the service. If you have any questions, please call the Member Services toll free phone number on your ID Card.

## **Provider Billing**

### ***What If I Get a Bill from my Perinatal Provider? Who Do I Call? What Information Will They Need?***

We will only pay for covered services listed previously in this member handbook. If you get a service from your Perinatal provider that is not covered, you may have to pay. If you feel that you should not have gotten the bill or you need help to understand the bill, please call the Member Services toll free phone number on your ID Card. We will help explain the bill to you. We can talk to the doctor's office for you to explain your benefits. We can also help you arrange for the bill to be paid. When you call us, please have your ID card and the doctor's bill with you. We will need this information so we can help you quickly.

## **What Extra Benefits Does Aetna Better Health Offer?**

Aetna Better Health members get the following value-added services and extra benefits:

### **Value-added Services**

- Informed Health Line -1-800-556-1555 – You can talk to a nurse 24 hours a day, 7 days a week. The nurse can help you with questions or help you decide what to do about your health needs. Only your doctor can give medical advice or medicines. The Informed Health nurses can give information on over 5,000 health topics. Call your doctor first with any questions or concerns about your health care needs.
- Sports Physical Exams –Aetna Better Health members 19 years and younger, can get one sports physical exam per year.

- Smoking Cessation Program –Aetna Better Health will offer smoking cessation benefits including assessment and counseling to Medicaid members 12 years of age and older. Nicotine replacement products to Medicaid members 18 years of age and older unless prescribed by a physician.
- Contact Lenses Program – Aetna Better Health will offer a benefit for contact lenses, including a fitting exam, with additional benefits to be applied towards the purchase of contact lenses to correct vision for members 12-18 years old.

**Extra Benefits**

- Free Member Newsletter – You will get a newsletter in the mail with information on health topics.
- Case Management - Nurses give you information about your health concerns and help coordinate services for high risk pregnant members.

**How Can I Get These Benefits for My Unborn Child?**

You do not have to go to your doctor to get these services. If you have questions or need help with these services, visit the website ([www.aetnamedicaid.com](http://www.aetnamedicaid.com)) or call us at the toll-free number on your ID card.

**What Health Education Classes Does Aetna Better Health Offer?**

We work with our community partners to make available free and/or low-cost classes for parents and children. Some health topics include:

Car Seat Safety	Poison Safety
Drug & Alcohol Awareness	Prenatal Care
Immunizations	Sexually Transmitted Diseases
Infant Mortality	Smoking Cessation
Nutrition	Teen Pregnancy Prevention
Oral Health	Vision Awareness
Physical Fitness	Weight Management

Please call us to learn more. Please check with your doctor before you begin any new health or wellness program.

**What Other Services or Programs are Available?**

There are other services that are not a part of Aetna Better Health. Your child can also be able to get some of these services or programs:

- Early Childhood Intervention (ECI) Program - ECI gives services to children ages 0 to 3 years whose development is delayed. Some of the services for children are: screenings, physical, occupational, speech and language therapy, and activities to help children learn better.
- Mental Illness or Mental Retardation (MHMR) Case Management - Coordination of care is given to help people get access to other needed services.
- Women, Infants, and Children (WIC) Program - WIC can help children under 5 years old and pregnant women to get nutritious food, nutrition education, and counseling.
- Texas Information and Referral Network (TIRN) – The phone number is 211. This is a **free** phone call which can help you find Health and Human Services in your local area.

# Health Care and Other Services

## Routine Medical Care

### *What Is Routine Medical Care?*

### *How Soon Can I Expect to be Seen?*

**Routine care** is the non-emergency or non-urgent care that you receive from your Perinatal Provider or other healthcare provider.

The Perinatal Provider you choose will help you with all your prenatal medical care. Your Perinatal Provider will get to know you and do regular check-ups on you and your unborn child. This type of care is known as routine medical care. Your Perinatal Provider will give you prescriptions for medicines and medical supplies and send you to a specialist if needed during your pregnancy. It is important that you follow your Perinatal Provider's advice and take part in decisions about your pregnancy.

When you need care, call your Perinatal Provider. Someone in the doctor's office or clinic will make an appointment for you. It is very important that you keep your appointments. Your Perinatal Provider should be able to see you within two (2) weeks after you ask for the routine care appointment. Call early to make appointments. If you cannot keep your appointment, call back to let the Perinatal Provider know.

## Urgent Medical Care

### *What Is Urgent Medical Care?*

### *How Soon Can I Expect to be Seen?*

**Urgent care** is when you have a medical problem that is **not** an emergency, including a cold, cough, small cuts, minor burns or bruises.

You must first call your Perinatal Provider at the number shown on your ID card. If you would like to speak to a nurse you can call the Informed Health Line at 1-800-556-1555. The nurse can help decide if you need to go to the emergency room. Many illnesses do not need to be treated in the ER. A cold, cough, rash, small cuts, minor burns or bruises are not good reasons to go to the ER. If you need urgent care, the Perinatal Provider should see you within 24 hours after you ask for care.

## Emergency Care

### *What Is Emergency Medical Care? How Soon Can I Expect to be Seen?*

### **What is an Emergency, an Emergency Medical Condition, and an Emergency Behavioral Health Condition?**

Emergency care is a covered service if it directly relates to the delivery of the unborn child until birth. Emergency care is provided for Emergency Medical Conditions and Emergency Behavioral Health Conditions. An **Emergency Medical Condition** is a medical condition of recent onset and severity, including, but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

- placing the unborn child's health in serious jeopardy;
- serious impairment to bodily functions as related to the unborn child;
- serious dysfunction of any bodily organ or part that would effect the unborn child;
- serious disfigurement to the unborn child; or
- In the case of a pregnant woman, serious jeopardy to the health of the woman or her unborn child.

**Emergency Behavioral Health Condition** means any condition, without regard to the nature or cause of the condition, that in the opinion of a prudent layperson, possessing average knowledge of medicine and health:

- requires immediate intervention and/or medical attention without which the mother of the unborn child would present an immediate danger to the unborn child or others; or

- that renders the mother of the unborn child incapable of controlling, knowing or understanding the consequences of her actions.

### **What are Emergency Services and/or Emergency Care?**

**“Emergency Services” and/or “Emergency Care”** are covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services and that are needed to evaluate or stabilize an Emergency Medical Condition and/or Emergency Behavioral Health Condition, including post-stabilization care services related to labor and delivery of the unborn child.

### ***Guidelines***

**Go to the nearest hospital if you think you have any of these problems. You may call 9-1-1 for help in getting to the hospital emergency room.**

- **If you go to the ER, be sure to call your Perinatal Provider within 24 hours.**
- **Be sure to show your Aetna Better Health CHIP Perinate ID card when you check in to the ER.**

### **After-Hours Care**

#### ***How Do I Get Medical Care After My Primary Care Provider’s Office is Closed?***

If you get sick at night or on a weekend and cannot wait to get medical care, call your Perinatal Provider. Your Perinatal Provider or another doctor is ready to help by phone 24 hours a day, 7 days a week. You may also call the 24-hour Informed Health Line® at 1-800-556-1555 to speak with a registered nurse to help you decide what to do. Remember to keep your CHIP Perinate ID card with you at all times.

### **Getting Care When Traveling**

#### ***What If I Get Sick When I Am Out of Town or Traveling Out of State? What If I Am Out of the Country?***

If you get sick while you are out of town or out of state, call your Perinatal provider. You may also call us at the number on your ID card. You may also call our Informed Health Line at 1-800-556-1555 and a nurse can help you decide what to do. However, if you are having an emergency, go to the nearest ER. Remember to keep your Aetna Better Health ID Card with you at all times. **Also remember that the Aetna Better Health CHIP Perinate program does not cover services outside of the United States.**

#### ***What does Medically Necessary Mean?***

Covered services for CHIP Perinate Members must meet the CHIP Perinatal definition of "Medically Necessary."

#### **Physical:**

- reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical malformation or limitations in function, threaten to cause or worsen a Disability, cause illness or infirmity of an unborn child, or endanger life of the unborn child;
- provided at appropriate facilities and at the appropriate levels of care for the treatment of an unborn child’s medical conditions;
- consistent with health care practice guidelines and standards that are issued by professionally recognized health care organizations or governmental agencies;
- consistent with diagnoses of the conditions; and
- no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
- are not experimental or investigative; and
- are not primary for the convenience of the mother of the unborn child or health care provider.

#### **Behavioral:**

- reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder to improved, maintain, or prevent deterioration of function resulting from the disorder;

- provided in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
- are not experimental or investigative; and
- are not primary for the convenience of the mother of the unborn child or health care provider

**Medically Necessary Services** must be furnished in the most appropriate and least restrictive setting in which services can be safely provided and must be provided at the most appropriate level or supply of service which can safely be provided and which could not be omitted without adversely affecting the unborn child's physical health and/or the quality of care provided.

## Explanation of Referral

### ***What is a Referral?***

A referral is an approval from your Perinatal Provider for you to go to another doctor or service for care.

### ***What Services Do Not Need a Referral?***

The following services **do not** require a referral and can be accessed directly:

- Emergency care
- Ob/Gyn care

### ***What If I Need Services that Are Not Covered by CHIP Perinatal?***

Call your Perinatal Provider to ask about ways to get services not covered by CHIP Perinatal.

## Medications

### ***What are my Unborn Child's Prescription Drug Benefits?***

CHIP covers most of the medicine your unborn child needs. If you have questions what drugs are covered for your unborn child, call us at the toll free number on your ID card.

### ***How Do I Get My Medications?***

CHIP Perinatal covers most of the medicine your unborn child's doctor says you need. Your doctor will write a prescription so you can take it to the drug store, or may be able to send the prescription for you.

There are no co-payments required for CHIP Perinate Members.

### ***How Do I Find a Network Drug Store?***

You can find a network pharmacy in one of two ways.

- Visit our website at [www.aetnamedicaid.com](http://www.aetnamedicaid.com), and then search for a pharmacy in your area.
- Call Member Services toll-free at **1-800-245-5380 (Tarrant)** or **1-866-818-0959 (Bexar)**. Ask the representative to help you find a network pharmacy in your area.

### ***What If I Go To a Drug Store Not In the Network?***

Prescriptions filled at other pharmacies that are not in the Aetna Better Health network will not be covered. All prescriptions must be filled at a network pharmacy.

### ***What Do I Bring With Me To the Drug Store?***

You will need to bring the prescription your doctor wrote for you. You will also need to show your Aetna Better Health ID card.

### ***What If I Need My Medications Delivered To Me?***

If you take medication for an ongoing health condition, you can have your medications mailed to your home. CVS Caremark is your mail service pharmacy.

If you choose this option, your medication comes right to your door. You can schedule your refills and reach pharmacists if you have questions. Here are some other features of home delivery.

- Pharmacists check each order for safety.
- You can order refills by mail, by phone, online, or you can sign up for automatic refills.
- You can talk with pharmacists by phone.

### **It's easy to start using mail service**

Choose ONE of the following three ways to use mail service for a medication that you take on an ongoing basis:

- Call the FastStart<sup>®</sup> toll-free number at 1-800-875-0867, Monday through Friday, 7 a.m. to 7 p.m. (CT). A representative will let you know which of your prescriptions can be filled through CVS Caremark Mail Service Pharmacy. CVS Caremark will then contact your doctor for a prescription and mail the medication to you.

When you call, be sure to have:

- Your Aetna Better Health member ID card
  - Your doctor's first and last name and phone number
  - Your payment information and mailing address
- Log on to [www.caremark.com/faststart](http://www.caremark.com/faststart). Going online is a quick and easy way to start using mail service. Once you provide the requested information, CVS Caremark will contact your doctor for a new prescription. If you haven't registered yet on [www.caremark.com](http://www.caremark.com), be sure to have your member ID card handy when you register for the first time.
  - Fill out and send a mail service order form. If you already have a prescription, you can send it to CVS Caremark with a completed mail service order form. If you don't have an order form, you can print one online or you can request one by calling toll-free 1-855-271-6603.
  - Please have the following information with you when you complete the form:
    - Your Aetna Better Health member ID card
    - Your complete mailing address, including ZIP code
    - Your doctor's first and last name and phone number
    - A list of your allergies and other health conditions
    - Your original prescription from your doctor.

If you need your prescription filled right away, ask your doctor to write two prescriptions for your long-term medication:

- One for a short-term supply (30 days or less) that can be filled at a participating network pharmacy AND
- One for the maximum days supply allowed by your plan, with refills as needed. Enclose this prescription along with the mail service order form.

### ***Who Do I Call If I Have Problems Getting My Medications?***

If you have a problem getting your medications, call us at the toll free number on your ID card.

### ***What if I Can't Get The Medication My Doctor Ordered Approved?***

If your doctor cannot be reached to approve a prescription, you may be able to get a three day emergency supply of your medication.

Call Aetna Better Health at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar) for help with your medications and refills.

### ***What If I Lose My Medication(s)?***

If you lose your medications, call us at the toll free number on your ID card.

### ***What if I Need an Over the Counter Medication?***

The pharmacy cannot give you an over the counter medication as part of your CHIP Perinate benefit. If you need an over the counter medication, you will have to pay for it.

### ***What if My Child Needs More than 34 Days of a Prescribed Medication?***

The pharmacy can only give your child as much of a medication as your child needs for 34 days. For any other questions please call Aetna Better Health at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar).

## **Other Member Services**

### **Interpreter Services**

#### ***Can Someone Interpret for Me When I Talk with My Perinatal Provider? Who Do I Call for an Interpreter?***

Our Member Services staff speaks both English and Spanish. We have a language line if you do not speak English or Spanish. If you need an interpreter, call us at the toll-free number on your ID card. At the time of your call, we will get a language interpreter that speaks your language on the line. People that are deaf or hearing impaired can call the TTY line toll-free at 1-800-735-2989.

#### ***How Can I Get a Face-to-Face Interpreter in the Provider's Office? How Far in Advance Do I Need to Call?***

We can help you if you need an interpreter to go with you to your doctor's office. As soon as you know the date of your appointment, please call us at the toll-free number on your ID card. We ask for 72 hours advance notice of a need for an interpreter.

### **Member Services Notification**

#### ***What Do I Have to Do If I Move?***

As soon as you have your new address, give it to the local HHSC benefits office and Aetna Better Health Member Services Department at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar). Before you get CHIP services in your new area, you must call Aetna Better Health, unless you need emergency services. You will continue to get care through Aetna Better Health until HHSC changes your address.

## **Member Rights and Responsibilities**

### **MEMBER RIGHTS**

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child's health plan, doctors, hospitals and other providers.
2. You have a right to know how the Perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.
3. You have a right to know how the health plan decides whether a Perinatal service is covered and/or medically necessary. You have the right to know about the people in the health plan who decide those things.
4. You have a right to know the names of the hospitals and other Perinatal providers in the health plan and their addresses.

5. You have a right to pick from a list of health care providers that is large enough so that your unborn child can get the right kind of care when it is needed.
6. You have a right to emergency Perinatal services if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.
7. You have the right and responsibility to take part in all the choices about your unborn child's health care.
8. You have the right to speak for your unborn child in all treatment choices.
9. You have the right to be treated fairly by the health plan, doctors, hospitals and other providers.
10. You have the right to talk to your Perinatal provider in private, and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.
11. You have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals and others who provide Perinatal services for your unborn child. If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
12. You have a right to know that doctors, hospitals, and other Perinatal providers can give you information about your or your unborn child's health status, medical care, or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

## **MEMBER RESPONSIBILITIES**

You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
2. You must become involved in the decisions about your unborn child's care.
3. If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.
4. You must learn about what your health plan does and does not cover. Read your CHIP Program Handbook to understand how the rules work.
5. You must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
10. You must report misuse of CHIP Program services by health care providers, other members, or health plans.
7. You must talk to your provider about the medications prescribed.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1-800-368-1019. You also can view information concerning the HHS Office of Civil Rights online at [www.hhs.gov/ocr](http://www.hhs.gov/ocr).

## **Plan Coverage**

***When Does CHIP Perinatal Coverage End? Will the State Send Me Anything When my CHIP Perinatal Coverage Ends?***

CHIP Perinatal coverage ends the last day of the baby's birth month. Yes, the State will send you a letter stating when your coverage ends.

### ***How Does Renewal Work?***

#### **Aetna Better Health CHIP Perinate Newborn Members**

You should get a renewal packet in the mail from the State during your child's 10th month of coverage. This packet will include a renewal application, a letter asking for current income and deduction information, and a postage paid envelope.

You should:

- Look over the information on the renewal application
- Update any information as needed
- Attach your current income and deduction verifications
- Sign and date the application
- Look over your health plan choice
- Return the application and other documents by the due date.

The renewal application is due by the 1st day of the 11th month of coverage. It is important that you pay your child's enrollment fee on time so there is no gap in coverage. For more information, please call the CHIP Help Line at 1-800-647-6558.

### ***Does My Baby Receive Benefits at Birth?***

Yes, your child will receive the same benefits as all other the CHIP members, except there are no co-pays while on CHIP Perinatal.

### ***Can I Choose My Baby's PCP Before He/She Is Born? Who Do I Call?***

#### ***What Information Do They Need?***

Yes, you can select a PCP before your child is born. You can do this by calling our Member Services Department at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar) and request an Aetna Better Health CHIP Perinate Newborn Provider Directory.

Remember: the PCP will be the one you call when your child needs care. Your child's Aetna Better Health CHIP or Aetna Better Health CHIP Perinate Newborn PCP is also part of a "network." When you choose this PCP, you also choose this PCP's network. This means that you should not take your child to any other provider who is not in the PCP's network, even if this provider is listed with Aetna Better Health CHIP and Aetna Better Health CHIP Perinate Newborn Provider Directory.

Look in your Aetna Better Health CHIP and Aetna Better Health CHIP Perinate Newborn Provider Directory for the names, addresses and telephone numbers of Aetna Better Health CHIP and Aetna Better Health CHIP Perinate Newborn Primary Care Providers, or call Member Services toll-free at **1-800-245-5380 (Tarrant)** or **1-866-818-0959 (Bexar)** for help. You can also see or print a copy of the Provider Directory at [www.aetnamedicaid.com](http://www.aetnamedicaid.com).

## **Member Safety**

We are committed to educating our members about health safety. Research shows that most medical errors can be prevented by being an active participant in your health care. Here are some important tips:

- *Be involved in every decision about your health care.* You are more likely to know what you and your provider can do to improve and/or maintain your health if you are involved with your health care.
- *Ask questions.* You have a right to question anyone who is involved with your care.
- *Make sure your provider knows about all medications you are taking,* including prescriptions, over-the-counter medications and dietary supplements such as vitamins and herbs. Ask that these be written down in your file.
- *Make sure your doctor knows if you have any allergies or bad reactions to medications.* This can help you avoid getting medications that could harm you.

- *Ask for information about your medical treatment in a language you can understand.* Be sure you know all the basics, such as medication dosage, drug interactions, possible side effects and why a particular medication and/or treatment is being recommended.

## Complaint Process

### Complaints

#### ***What Should I Do if I Have a Complaint? Who Do I Call?***

We want to help. If you have a complaint, please call us toll-free at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar) to tell us about your problem. An Aetna Better Health Member Advocate can help you file a complaint. Most of the time, we can help you right away or at the most within a few days.

#### ***Can Someone from Aetna Better Health Help Me File a Complaint?***

The Member Advocate can help you file a complaint. The Member Advocate will write down your concern. You can also send a written complaint to the Member Advocate at:

Aetna Better Health  
Attention: Member Advocate  
PO Box 569150  
Dallas, TX 75356-9150  
or call toll-free 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar)

#### ***How Long Will It Take to Process My Complaint? What are the Requirements and Timeframes for Filing a Complaint?***

When we get the complaint from you, we will send you a letter within five (5) days to let you know that we got it. We will send you another letter within thirty (30) days from the date we got your complaint that will give you the results.

#### ***If I am Not Satisfied with the Outcome, Who Else Can I Contact?***

If you are not happy with the result of your complaint, you can call us at the toll-free number on your ID card and ask for an appeal. You can also ask for an appeal of a complaint resolution by writing to:

Aetna Better Health  
Attention: Member Advocate  
PO Box 569150  
Dallas, TX 75356-9150  
or call toll-free 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar)

#### ***Do I Have the Right to Meet with a Complaint Appeal Panel?***

Within five (5) days of getting your request for an Appeal, the Member Advocate will send you a letter to let you know that your appeal came to us. The Appeal Panel will look over the information you submitted and discuss your case. It is not a court of law. You have the right to appear in front of the Appeal Panel at a specified place to talk about the written appeal you sent us. When we make the decision on your appeal, we will send you a response in writing within thirty (30) days after we get the appeal.

You also have the right to file a complaint with the Texas Department of Insurance (TDI) by calling toll free at 1-800-252-3439, or in writing at:

Texas Department of Insurance  
Consumer Protection  
PO Box 149091  
Austin, TX 78714-9091  
  
Fax: (512) 475-1771  
Web: <http://www.tdi.state.tx.us>  
Email: [ConsumerProtection@tdi.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)

## Appeal Process

### Appeal

#### ***What Can I Do if My Doctor Asks for a Service or Medicine for me That's Covered but Aetna Better Health Denies or Limits It ?***

If we deny or limit your doctor's request for a covered service or medicine for you, you have the right to ask for an appeal. You or your doctor can send us more information to show why you do not agree with the decision. You can call us and ask for an appeal. The Member Advocate will write down the information and send it to you to look over. A written appeal can be sent to:

Aetna Better Health  
Attention: Member Advocate  
PO Box 569150  
Dallas, TX 75356-9150

#### ***How Will I Find Out If Services are Denied?***

If your services are denied, you and your doctor will get a letter that tells you the reason for denial. The letter will also tell you how to file an appeal and how to ask for a review by an Independent Review Organization (IRO).

#### ***What are the Timeframes for the Appeal Process?***

You can appeal a decision to deny services at any time after you are told of the decision. The timeframe for the resolution of the appeal will depend on what services have been denied. If you are in the hospital or is already getting services that are being limited or denied, you can call and ask for an expedited appeal. The expedited appeal process is explained on the next page.

For a standard appeal, the Member Advocate will send you a letter within five (5) days of getting your request for an Appeal to let you know that we got it. We will send all available information to a doctor who was not involved in making the first decision. You will get a written response on your appeal within thirty (30) days after we get the appeal.

#### ***When Do I Have the Right to Ask for an Appeal?***

If you don't agree with the decision made by us, you can ask us for an appeal. You do not have a right to an appeal if the services you asked for are not covered under the CHIP program or if a change is made to the state or federal law, which affects CHIP members.

#### ***Does My Request Have to be in Writing?***

Your request does not have to be in writing. You can ask for an appeal by calling us at the toll-free number listed on your ID card and ask for the Member Advocate. We will write down what you tell us and send it to you to review

#### ***Can Someone from Aetna Better Health Help Me File an Appeal?***

You can get help in filing an appeal by calling us at the toll-free at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar) or writing to:

Aetna Better Health  
Attention: Member Advocate  
PO Box 569150  
Dallas, TX 75356-9150

The Member Advocate will listen to your appeal and tell you about the rules. The Member Advocate will answer your questions and see that you are treated fairly.

## Expedited Appeal Process

### Expedited Appeal

### ***What is an Expedited Appeal?***

An Expedited Appeal is when a health plan has to make a decision quickly based on the condition of your health, and taking time for a standard appeal could jeopardize your life or health.

### ***How do I Ask for an Expedited Appeal?***

You can ask for an expedited appeal by calling us toll-free number at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar). A written expedited appeal can be sent to:

Aetna Better Health  
Attention: Member Advocate  
PO Box 569150  
Dallas, TX 75356-9150

### ***Does My Request Have to be in Writing?***

Your request does not have to be in writing. You can ask for an expedited appeal by calling us at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar).

### ***What are the Timeframes for an Expedited Appeal?***

The timeframe for resolution of your request of an expedited appeal will be based on your medical emergency condition, procedure, or treatment, but will not take more than one (1) business day from the date we get all information needed to review your appeal.

### ***What Happens if Aetna Better Health Denies the Request for an Expedited Appeal?***

If you ask for an expedited appeal that does not involve an emergency, a hospital stay or services that are already being given, you will be told that the appeal review cannot be rushed. We will keep working the appeal and respond to you within thirty (30) days from the time we got your appeal.

If you do not agree with this decision, you can ask for an outside review by an Independent Review Organization (IRO). The procedure to ask for a review by an IRO is explained below. You can also file a complaint with the Texas Department of Insurance by calling toll free at 1-800-252-3439 or writing to:

Texas Department of Insurance  
Consumer Protection  
PO Box 149091  
Austin, TX 78714-9091

Fax: (512) 475-1771

Web: <http://www.tdi.state.tx.us>

Email: [ConsumerProtection@tdi.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)

### ***Who Can Help Me in Filing an Appeal?***

You can ask for an appeal by calling us at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar) and asking for the Member Advocate or writing to:

Aetna Better Health  
Attention: Member Advocate  
PO Box 569150  
Dallas, TX 75356-9150

The Member Advocate will listen to your appeal and tell you about the rules. The Member Advocate will answer your questions and see that you are treated fairly.

### **Independent Review Organization (IRO)**

### **What is an Independent Review Organization (IRO)?**

An IRO is an organization that has no connection to us or the doctors that were previously involved in your treatment or decisions made by us about services that have not been given.

### **How Do I Ask for a Review by an Independent Review Organization?**

You can ask for an IRO review by filling out the "Request For A Review By An Independent Review Organization" form that is sent with the decision letter. You will have 15 days from the day you get our decision letter to send it back to us. Once we get the completed form, we will tell the Texas Department of Insurance (TDI) of your request for an IRO review. There is no cost to you for an independent review.

If you need help filling out the IRO form, please call the toll-free number on your ID card. We will be happy to help you.

### **What are the Timeframes for this Process?**

The standard timeframe for the IRO process should take no longer than twenty (20) calendar days from the date the IRO gets all of your information.

If you have an emergency health condition, the IRO process should take no longer than eight (8) calendar days from the date the IRO gets all of your information.

## **Fraud Information**

### **Do you want to report CHIP Waste, Abuse, or Fraud?**

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting CHIP benefits is doing something wrong. Doing something wrong could be waste, abuse or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their CHIP ID.
- Using someone else's CHIP ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

### **To report waste, abuse, or fraud, choose one of the following:**

- Call the OIG Hotline at 1-800-436-6184;
- Visit <https://oig.hhsc.state.tx.us/> and pick "Click Here to Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to your health plan:
  - Aetna Better Health
  - Attention: SIU Coordinator
  - PO Box 569150
  - Dallas, TX 75356-9150
  - 1-855-771-8072 (toll-free)

### **To report waste, abuse or fraud, gather as much information as possible.**

When reporting about a provider (doctor, dentist, counselor, etc) include:

- Name, address and phone number of provider;
- Name and address of the facility (hospital, nursing home, home health agency, etc);
- Medicaid number of the provider and facility, if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc);
- Names and the number of other witnesses who can help in the investigation;
- Dates of events; and
- Summary of what happened.

When reporting about someone who gets benefits include:

- The person's name;
- The person's date of birth, Social Security Number, or case number if you have it
- The city where the person lives
- Specific details about the waste, abuse or fraud

## **Subrogation**

### **Subrogation**

#### ***What is subrogation?***

We might ask for payment for medical expenses to treat an injury or illness that was caused by someone else. This is a "right of subrogation" provision. Under our right of subrogation, we reserve the right to get back the cost of medical benefits paid when another party is (or might be responsible) for causing the illness or injury to you. We can ask to get back the cost of medical expenses from you if you get expenses from the other party.